Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Significant changes to the renewal of this waiver:
1) Revisions to service definitions for day habilitation, vocational planning, retirement, community living and day supports, and respite;
2) Addition of a new service option;
3) Termination of Behavioral Risk service;
4) Termination of Medical Risk service; and
5) Addition and revisions of provider qualifications for the new service and team behavioral consultation.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Nebraska** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
Day Services waiver for adults with DD

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NE.0394
Draft ID: NE.016.03.00

D. Type of Waiver *(select only one):*
Regular Waiver

E. Proposed Effective Date: *(mm/dd/yy)*
01/01/16

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:
☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
Purpose:
The Nebraska Department of Health and Human Services (DHHS) Division of Developmental Disabilities (DDD) offers a menu of services and supports intended to allow individuals with intellectual or developmental disabilities (DD) to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. A combination of non-specialized and specialized services are offered under this waiver for adults, age 21 years or older, and their families as appropriate, to allow choice and flexibility for individuals to purchase the services and supports that only that person may need or prefer.

Non-specialized services are services directed by the individual or family/advocate and delivered usually by independent providers. These self-directed, or participant-directed, services are intended to give the individual more control over the type of services received as well as control, or choice of the direct providers of those services.

Specialized services are traditional habilitation services that provide residential and day habilitative training and are delivered by certified DD agency providers.

Goals:
Prevent institutionalization in an ICF or nursing facility for individuals whose needs can be met by community based DD providers.

Promote a high quality of service delivery in community based services.

Expand participant direction of services.

Objectives:
Have a sufficient number of waiver slots each year of the waiver in order to have waiver services available to individuals who meet the eligibility criteria.

Continue to work with the Division of Medicaid and Long-Term Care (DMLTC), the Division of Public Health (DPH), DDD Service Coordination, DDD Disability Services Specialists (DSS), and the DDD Quality Improvement Committee (QIC) to develop and enhance a statewide quality improvement plan.

Share and make use of all monitoring data.

Monitor provider quality assurance activities.

Organizational Structure and Service Delivery:
DHHS DDD, a Division within the single State Medicaid agency operates the or Day Services Home and Community Based Services (HCBS) waiver for adults with developmental disabilities. DHHS executes provider agreements for independent providers to deliver non-specialized services to eligible individuals. DHHS staff certify DD provider agencies and DDD contracts with certified DD provider agencies to deliver specialized habilitation services. DHHS DDD staff located across the state determines eligibility for this fee-for-service waiver. Services are prior authorized by DDD staff and individualized funding is based on an objective assessment process.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- [ ] **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the

following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The following strategies were used to secure public input for this waiver renewal:

Beginning July 13, 2015, public input was solicited through direct conversations with eligible individuals and/or their guardians, the DHHS public website, electronic notification to DD provider agencies, the Nebraska DD provider association and advocacy groups, and non-electronic public notice in a newspaper with statewide circulation. The public notice comment period allows at least 60 days for comment before the anticipated submission date and includes written notification to all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State in accordance with the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Indian health programs, and Urban Indian Organizations. Evidence of the applicable notices is available through the Medicaid Agency.

In accordance with 42 CFR 441.304(f), the state provided at least a 30 day public notice and comment period. In fact, the draft waiver renewals were posted to the DDD public website on July 15, 2015 for a 60 day public notice and comment period.

The full waiver renewal application and a summary of the changes in the waiver were posted on the public website on 7/15/2015 and were also available upon request in hard copy. Public comments could be provided via the internet, e-mail, fax, U.S. mail, or phone calls. The full waiver renewal application and a summary of the changes in the waiver are on the DHHS public website under Developmental Disabilities at http://dhhs.ne.gov/developmental_disabilities/Pages/developmental_disabilities_index.aspx.

The following language was posted 7/13/15 in the Omaha World-Herald, a newspaper with statewide circulation:
SEEKING PUBLIC COMMENT:
Pursuant to 42 C.F.R. §441.304(f), the Nebraska Department of Health and Human Services (DHHS) is required to give public notice related to the state's plan to renew two Medicaid Home and Community-Based Services (HCBS) waivers for adults with developmental disabilities. Upon approval by the Centers for Medicare and Medicaid (CMS), the HCBS waivers would go into effect January 1, 2016.

The two draft HCBS waiver applications and a summary of changes in the applications can be viewed on the Department's website beginning 7/15/2015 at http://dhhs.ne.gov/developmental_disabilities/Pages/developmental_disabilities_index.aspx . The waiver applications and a summary of changes can also be requested via mail, email, or by phone at 877-667-6266.

Interested persons are invited to submit written comments to DHHS. Written comments must be postmarked or received by 5:00 P.M. 09/15/2015 and should be emailed to DHHS.HCBSPublicComments@nebraska.gov, faxed to 402-471-9449 attention Pam Hovis, or sent to Department of Health and Human Services, Division of Developmental Disabilities, Attention: Pam Hovis, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026.

An e-mail for stakeholder notice and comment period with attachments of the draft waivers and summary of the changes was sent to DDD staff, advocacy groups, the Nebraska DD Provider association, DD provider agency directors, and interested parties on July 14, 2015. The stakeholder notice and e-mail are available to CMS upon request. DD Service Coordination staff were provided a conversation guide to use with individuals on the SC's caseload and families and/or guardians as applicable, during the SC's regular monthly contact.

On July 14, 2015 the Nebraska area tribal government and agencies were notified by the Division of Medicaid and Long Term Care of the plan to submit applications to CMS for the renewal of waiver 0394 and 0396. The notification provided contact information for questions and comments and opportunities for public comment.

Prior to submission of the application to CMS, a summary of the comments received during the public notice and

comment period will include any modification made to the waiver renewal application based upon those comments as well as the reasons whey comments were not adopted. The state has maintained the public comments for CMS review.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Hovis

First Name: Pam

Title: Waiver Manager, Division of Developmental Disabilities

Agency: Nebraska Department of Health and Human Services

Address: P.O. Box 98947

Address 2: 301 Centennial Mall South

City: Lincoln

State: **Nebraska**

Zip: 68509-8947

Phone: (402) 471-8717 **Ext:** ☐ **TTY**

Fax: (402) 471-8792

E-mail: pam.hovis@nebraska.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Nebraska**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Miller

First Name: Courtney

Title: Deputy Director

Agency: Nebraska Department of Health and Human Services

Address: Nebraska State Office Building, 5

Address 2: 301 Centennial Mall South

City: Lincoln

State: **Nebraska**

Zip: 68509

Phone: (402) 471-9185 **Ext:** ☐ **TTY**

Fax: (402) 471-9092

E-mail: courtney.miller@nebraska.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☑ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☑ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

This is an application to renew the approved waiver. Individuals served in the existing waiver are also eligible to participate in the renewed waiver. Services offered in the renewed waiver will include the same services offered in the approved waiver as well as an additional service and elimination of two unused services. The unduplicated count of participants is reduced to align with actual utilization of slots, based on actual data in years 1 - 4 of the approved waiver.

Day Habilitation, Integrated Community Employment, Respite, Assistive Technology and Supports, Community Living and Day supports, Home Modifications, Personal Emergency Response System, Retirement service, Team Behavioral Consultation service, Vehicle Modifications, Vocational Planning service, and Workstation service will continue to be offered under this waiver.

Medical Risk Service and Behavioral Risk Service will no longer be offered under this waiver. During the duration of the approved waiver, there were no (zero) individuals utilizing Medical Risk Service and Behavioral Risk Service. Should an individual on this waiver need Medical Risk service or Behavioral Risk service, the individual will be offered another DD waiver, 0396, which includes the needed service. There would be no gap in services or negative impact to the health and welfare of persons who need Medical Risk service or Behavioral Risk service.

Supported Integrated Employment service will be added to this waiver. As applicable, supported integrated employment will

be prior authorized and there will be no gap in waiver services for individuals that choose the new service.

Prior to implementation of Supported Integrated Employment service, individuals, family/advocates, DDD service coordination staff, and DD agency provider staff will be provided information through a variety of methods. The service definition and limits to the amount, frequency, or duration were shared verbally and made available in hardcopy and electronically.

On an individual basis, just prior to their next annual or semi-annual service plan meeting, whichever comes first, the service coordinator will review and discuss the individual's budget and all available waiver services, including the Supported Integrated Employment. The SC will assist the individual and/or family/legal representative as necessary to review their budget, determine services to be purchased, and to choose providers to deliver the chosen services. Individuals may choose to have the same services, same amount of services, and same providers, and in those cases, there will be very little apparent changes.

The participant is informed of the opportunity to request a Fair Hearing.

Initially, when a person is determined eligible or ineligible for DD services and with each written notice of decision, the individual and his/her legal representative are informed of and receive a copy of the right to appeal.

The Rights and Obligations form, is provided to the individual and his/her legal representative upon initial referral to services, at the time funding is authorized, and annually at the service plan meeting. The right to have action initiated on their request within 45 days, the right to receive written notice of any decision, the right to appeal a decision, and the right to request a fair hearing within 90 days of the notice of decision is printed on the document.

The Notice of Decision form, is used for eligibility determinations for DD services and funding decisions. "Your Rights" is printed on the document and includes the right to appeal and an explanation of an opportunity for an informal dispute resolution.

The Consent/Request for (waiver) Services form, which is used to document consent to receive waiver services and choice between receiving community based waiver services and institutional services also has the right to appeal information printed on the document.

The Service Coordinator provides the right to appeal information to individuals.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

The following service settings are included in this waiver and will be evaluated for compliance with federal HCB settings requirements: Day Habilitation service, Vocational Planning service, Workstation service, Respite, and Retirement.

The following service settings will not be assessed: businesses and public buildings where Integrated Community Employment, Supported Integrated Employment, and Community Living and Day Supports are delivered. These services will continue to meet HCB Setting requirements through already existing prohibitions of these services from being provided in provider-owned and controlled settings. The following services are not specific to settings but rather are a type of service delivered to individuals, and therefore will not be assessed.

- Team Behavioral Consultation,
- Assistive Technology and Supports,
- Personal Emergency Response System,
- Home Modifications, and
- Vehicle Modifications.

The following DHHS resources will be utilized by DHHS staff to evaluate and identify service settings that are in compliance with the CMS HCBS rule as well as to identify service settings that are "likely not" community: Provider listings, provider site reviews and compliance surveys, participant experience surveys, self-advocate/family surveys, service coordination monitoring tools, provider self-assessments, and stakeholder meetings.

Applicable to waiver 0394, a review of regulatory compliance in thirty nine areas will be conducted, as identified in the HCBS Transition Plan Matrix – Comprehensive which is posted on the DHHS public website at http://dhhs.ne.gov/developmental_disabilities/Pages/developmental_disabilities_index.aspx. Needed changes in HCBS waivers, state regulations and internal guidelines that don't comport with all requirements of the rule will be identified and initiated. Provider Self-Assessment tools and Self-Advocate/Family Surveys have been developed to provide information to the state regarding the community nature of day settings and to identify day that are "likely not" community. Needed changes in data sources and performance metrics that relate to and/or demonstrate the current level of compliance with the CMS rule will be identified and initiated. Data sources to be used to measure transition plan activities outlined in the Gantt chart (pages 86 – 91) will be utilized.

The first part of this section describes the strategies that were utilized to gather and consider public input. The second part of this section, divided by a line, specifies the state's process to bring this waiver into compliance with federal HCB settings requirements.

The state secured public input into the development of the transition plan for the amendment to this waiver, approved in July 2015.

Input on Settings Requirements Prior to Draft Transition Plan(s):

Nebraska's Department of Health and Human Services (DHHS) has initiated a comprehensive review of Nebraska's HCBS waivers and related regulations, policy and procedures to assess and identify changes necessary to comply with the new CMS HCBS rules and ensure people receiving long term services and supports have the same opportunity to access their community that all Nebraska's citizens enjoy. The services currently under review include the Adult Day Waiver at http://dhhs.ne.gov/developmental_disabilities/Documents/Nebraska-DDADwaiver-2011.pdf, and at http://dhhs.ne.gov/developmental_disabilities/Documents/AmendedDDADWaiverNE0394.pdf, and the Developmental Disabilities Rules and Regulations, found in Title 404 of the Nebraska Administrative Codes at http://dhhs.ne.gov/Pages/reg_t404.aspx.

DDD has shared information regarding the CMS rule and related guidance (including the various webinars) since January 2014 with our stakeholders. With significant impacts anticipated to developmental disability day services, targeted collaboration with developmental disability service providers and other stakeholders was initiated. Service provider representatives even participated with Nebraska staff in our Lincoln office for one of the webinars presented by CMS.

DDD leadership has met monthly with the Nebraska Association of Service Providers (NASP) since July 2014, and NASP was provided multiple opportunities to offer informal and formal input on the transition plan and issues related to the settings challenges. In August 2014, this collaboration resulted in NASP's website publication and outreach efforts to families and provider staff most impacted by the rule to provide education and support prior to the anticipated issuance of the draft transition plan.

The new settings requirements are going to require significant organizational changes of many of our developmental disabilities service providers. Our providers have been active collaborators in this process to ensure that Nebraska continues to

provide appropriate services to meet the needs of our vulnerable citizens. With the support of the Nebraska Planning Council on Developmental Disabilities, several providers have already started working with consultants to reorganize their services to promote integrated recreation and community employment, with great initial success. We share a common dedication to supporting individuals with developmental disabilities in our communities with quality services, and appreciate their collaboration through this process.

Multiple forms of public notice were utilized to inform stakeholders that the transition plan was available for public comment.

Nebraska provided a 39 day public notice and comment period (September 5, 2014 through October 14, 2014), providing for the following public input opportunities:
• Emailing to DHHS.HCBSPublicComments@nebraska.gov;
• Faxing to 402-471-9449 attention Christina Mayer;
• Mailing written comments to the Department of Health and Human Services, Attention: Christina Mayer, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026;
• Providing in person comments at public meetings; and/or
• Calling Christina Mayer at 1-877-667-6266.

Notice was provided in the following manner:
• Notification to the Nebraska Association of Service Providers on August 25, 2014;
• Publication in the Omaha World-Herald, a newspaper with statewide circulation on August 29, 2014;
• Delivery via U.S. postal service of a postcard announcement to all recipients of developmental disability services, as well as all individuals on DDD's eligibility registry (i.e. people who are eligible for services, but not currently receiving services) on September 1, 2014;
• Notification of Amendments and proposed State Transition Plan to Nebraska Tribal associations on September 4, 2014;
• Publication on the Nebraska Department of Health and Human Services website, with a specific HCBS Waivers State Transition Page created specifically to support this process (with links to this webpage from both the MLTC and the DDD webpages) on September 5, 2014;
• Email to all DDD staff, DD agency providers, the DD Planning Council, DD Advisory Committee, the ARC of Nebraska, Disability Rights of Nebraska, the Legislative Ombudsman's Office and the Nebraska Legislative Special Committee on Developmental Disabilities on September 5, 2014;
• Publication in the Omaha World-Herald, a newspaper with statewide circulation on September 7, 2014;
• Publication in the Munroe Meyer Institute Update, an electronic newsletter circulated broadly to stakeholders throughout Nebraska by our University Center for Excellence, on September 12, 2014.

The following language was posted 8/29/2014 in the Omaha World-Herald, a newspaper with statewide circulation:
MEETING NOTICE The Nebraska Department of Health and Human Services (DHHS) will hold public hearings to accept comments on the Department's proposed plans to ensure compliance with new Federal rules which require home and community based services to be provided in "community-like" settings. At these public hearings, DHHS will provide an overview of the requirements of Final Rule CMS 2249-F and CMS 2296-F published in the Federal Register on 1/16/14 which became effective 3/17/14. Hearings will be held from 1 to 3 pm CST on:
• 9/29/14 – Niobrara Room, Kearney Public Library, 2020 1st Ave, Kearney, Nebraska
• 9/30/14 – Lower Level B, Nebraska State Office Building, 301 Centennial Mall South, Lincoln, Nebraska
Interested persons are invited to submit written comments or to attend and comment at the hearing. Written comments must be postmarked or received by 5:00 P.M. 10/02/14 and should be emailed to DHHS.HCBSPublicComments@Nebraska.gov, faxed to 402-471-9449 attention Christina Mayer, or sent to Department of Health and Human Services, Attention: Christina Mayer, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026.
The transition plan and background materials can be viewed on the Department's website beginning 09/02/2014 at http://dhhs.ne.gov/Pages/hcs.aspx. The transition plan and background materials can also be requested via mail, email, or by phone at 877-667-6266.
If auxiliary aids or reasonable accommodations are needed to participate in the hearing, please call 877-667-6266. For persons with hearing impairments, please call DHHS at 402-471-9570 (voice and TDD) or the Nebraska Relay System at 711 or 800-833-7352 TDD at least 2 weeks before the hearing date.

A supplemental public notice was posted on September 7, 2014 in the Omaha World-Herald: SUPPLEMENTAL PUBLIC NOTICE Pursuant to 42 C.F.R. §441.301(c)(6)(iii), the Nebraska Department of Health and Human Services (DHHS) is required to give public notice related to the state's plan to comply with new regulation governing the settings in which the delivery of services to Medicaid Home and Community-Based Services waiver recipients may be provided.
Home and Community-Based Waiver Services

Settings Transition Planning
In accordance with and related to new Home and Community-Based Services Settings regulations found at 42 C.F.R. §441.301 (c)(4)-(5) requiring transition planning per 42 C.F.R. §441.301(c)(6), the state must submit a plan detailing actions to achieve compliance with the setting requirements. A public notice and comment period of at least 30 days is required for the proposed transition plan. The transition plan is required in conjunction with any waiver amendment or renewal submitted following the implantation of the new regulation which became effective March 17, 2014.
The state's transition plan will be developed with stakeholder input to include public comment through multiple methods. The schedule for transition planning activities and other related information for participating in and submitting comment is posted on the Department's website at dhhs.ne.gov. Initial and ongoing comment may be submitted to the designated e-mail address: DHHS.HCBSPublicComments@nebraska.gov. This public notice and transition plan is available for review on the DHHS website at http://dhhs.ne.gov/Pages/hcs.aspx. A copy of the transition plan is available with the public notice. Services Coordination staff will make available hard copies of the transition plan to any participant or applicant to the waiver upon request. In addition to the schedule of other comment submission options, an opportunity for public comment will be held at the following locations:
City Date/Time Location and Waiver Specific Presentations
Kearney Sept. 29, 2014; 1:00 – 3:00 p.m. CDT
Niobrara Room, Kearney Public Library, 2020 1st Avenue
All waivers will Be Presented

Lincoln Sept. 30, 2014; 1:00 – 4:30 p.m. CDT
Lower Level B, Nebraska State Office Building, 301 Centennial Mall South
All Waivers Will Be Presented

Omaha Oct. 7, 2014; 9:00 a.m. CDT
Metro Community College, 5330 North 30th St, Building 10 Room 110
Medicaid & Long Term Care Managed Waivers

Sidney Oct. 9, 2014; 9:00a.m. MDT
Western Nebraska Community College, Room 115, 371 College Dr.
Medicaid & Long Term Care Managed Waivers
Individuals who are disabled and need assistance to participate during this meeting should call (877) 667-6266. Individuals wishing to comment in writing on any of the proposed changes should do so on or before October 15, 2014, to the Department of Health and Human Services, attention: Christina Mayer, 301 Centennial Mall South, P.O. Box 95026, Lincoln, NE 68509-5026.

The matrices were presented at public meetings held in Kearney (September 29, 2014), Lincoln (September 30, 2014), Omaha (October 7, 2014), and Sidney (October 9, 2014). Evidence of Public Notice is posted on the DHHS public website in a fifty-two page document. Evidence of Public Notice is posted on the DHHS public website in a fifty-two page document.

The timeline for collecting, collating, analyzing, and incorporating public comments is identified in the Transition Plan Matrix. DD staff have reviewed, incorporated, and responded to all public comments. All public comments were considered, and responses were prepared and are included with the final plan in a ninety page document. Comments were received from email, fax, and public meetings. Included on the website is a matrix that identifies all 48 comments by date received, applicable waiver directed, commenter identity, source, response (which includes a brief summary of the comment content), whether the plan changed as a result of the comment, and the rationale for why the plan did or did not change.

Most commenters were supportive of the HCBS Rule and the transition process, but others were concerned about the transition process and fear that their current services will not be funded in the future by HCBS waiver funds. As noted in many comment responses, the Identification and Analysis activities noted in the transition plan are important in this respect as Nebraska evaluates current settings for compliance and analyzes options for transitioning all HCBS settings to become compliant with rule. Those activities include stakeholder input, which will allow such concerns raised by commenters to be addressed in the transition process.

Comments were received from email, fax, and public meetings. Forty-eight comments were received and most comments addressed multiple topics. Most commenters were supportive of the HCBS Rule and the transition process, but others were concerned about the transition process and fear that their current services will not be funded in the future by HCBS waiver funds. As noted in many comment responses, the Identification and Analysis activities noted in the transition plan are important in this respect as Nebraska evaluates current settings for compliance and analyzes options for transitioning all HCBS

settings to become compliant with rule. Those activities include stakeholder input, which will allow such concerns raised by commenters to be addressed in the transition process.

Listed below are comments by topics, the number of comments by topic, and the related comment content.

Current Services and Person-Centered Practice – 31
• Compliments of Nebraska's Assisted Living (AL) service and appreciation of service availability in rural areas
• Concern for safety for persons with dementia that receive AL service in special memory units
• Preference for continuation of sheltered workshops, residential congregate settings, and other "controlled environments".
• Recommendations for regulatory changes needed to fully comply with rule
• Comments related to specific individuals or services - Assisted Living service, group home service, extended family home service, Quality Living facility, in-home residential service, and Community Living and Day Supports service
• Concern that people with a guardian or Power of Attorney might be treated differently,
confined to congregate settings, or that the State will make decisions about where people live and work
• Concern of impact of lease/rental agreement requirement on individuals
• Suggest improvement in AL service - eliminating use of medication carts, providing more choice about when and where people can eat, providing condiments for seasoning to preference, and providing access to microwave, coffee pot, beverages, healthy snacks that people can help themselves to when they want
• Request for funding for people waiting for state funding for DD services
• Request for funding for Autism Waiver

Format and details of the Plan – 26
• Appreciation of broadness of plan to allow flexibility and adjustments
• Suggest definitions or clarification of terminology used in rule and statewide transition plan – "home-based" services, community-based services, sheltered workshop, "home-like" settings, "community-like", and privacy.
• Preference of narrative description of activities and more detailed description of the state's assessment activities
• Described as confusing and not easy to read

Development and Implementation of the Transition plan – 26
• Offers to help develop assessment tools and quality improvement processes
• Recommendation that QI process include complaint mechanism
• Encouragement that DHHS continue to utilize public comment for all DHHS programs
• Request to see list of settings that will be deemed "not likely" to meet community criteria
• Appreciation of in-person meetings, concern of accessibility of one meeting location and availability of transportation to in-person meetings.
• Suggest educational materials about rule and state's implementation be developed and disseminated
• Suggest more funding for transportation to better access community activities
• Expressed timelines are reasonable and overall, the plan will improve lives of people with disabilities
• Inquiry of funding sources for implementation and compliance with federal rule

Many great ideas were shared by stakeholders, and those ideas will be incorporated into the multi-year implementation of the current transition plan. Most of the public comments were supportive of the HCBS Rule and transition process and, therefore, Nebraska determined that no substantive changes to the transition plan were necessary. To address some formatting and terminology questions and concerns, Nebraska has added Supplemental and Clarifying Information to the final transition plan. However, no substantive changes were made to the initial plan. The state will continue to listen to stakeholders, seriously consider the impact to Nebraska citizens, and respond accordingly through waiver renewals, waiver amendments, or revisions to the statewide transition plan.

An opportunity for public comment was sought following the completion of provider self-assessments and development of a state survey tool. The following language was posted 7/1/15 in the Omaha World-Herald, a newspaper with statewide circulation:
The Nebraska Department of Health and Human Services (DHHS) will hold public meetings to accept comments on the Department's Transition Plan to ensure compliance with Federal rules which require home and community based services to be provided in "community-like" settings. At these public meetings, DHHS will provide a brief overview of the requirements of Final Rule CMS 2249-F and CMS 2296-F published in the Federal Register on 1/16/14 which became effective 3/17/14. DHHS will provide an update regarding the scheduled day and residential site reviews which will be conducted over the next several months and the draft tools DHHS intends to utilize to complete the reviews. Open meeting dates, times and locations:

Scottsbluff/Gering
08/05/2015
5:30-7:00 p.m. MST
Western Nebraska Community College
2620 College Park Drive Room C-139
Scottsbluff, NE 69361

Kearney
08/17/2015
3:00-4:00 p.m. CST
Educational Service Unit #10
76 Plaza Blvd
Kearney, NE

Grand Island
09/02/2015
3:00-4:00 p.m. CST
Nebraska Department of Health and Human Services
208 N. Pine Street
Grand Island, NE

Norfolk
09/22/2015
4:00-5:00 p.m. CST
Lifelong Learning Center
601 E Benjamin Avenue
Norfolk, NE

Lincoln (Live MTG and Video Conference)
09/24/2015
1:30-3:30 p.m. CST
NET Board Room
1800 North 33rd Street, Lincoln, NE 68503
Video Conferencing Sites available:
• Columbus – Columbus Public Library, Columbus Room Second Floor, 2504 14th Street, Columbus, NE 68601
• North Platte – ESU #16, Distance Learning Room 1221 W 17th Street, North Platte, NE 69101
• Omaha – Omaha State Office Building, Room 207, 1313 Farnam, Omaha, NE 68102

Interested persons are invited to submit written comments or to attend and comment at the meeting. Written comments must be postmarked or received by 5:00pm 09/30/2015 and should be emailed to DHHS.HCBSPublicComments@nebraska.gov, faxed to 402-471-9449 attention Bernie Hascall or sent to Department of Health and Human Services, attention Bernie Hascall, 301 Centennial Mall South, PO BOX 95026, Lincoln, NE 68509-5026.

The Transition Plan, draft assessment tool and background materials can be viewed on the Department's website beginning 07/01/2015 at http://dhhs.ne.gov/Pages/hcs.aspx. The Transition Plan, draft tools and background materials can also be requested via mail, email or by phone at 877-667-6266.

If auxiliary aids or reasonable accommodations are needed to participate in the hearing, please call 877-667-6266. For persons with hearing impairments please call DHHS at 402-471-9570 (voice and TDD) or the Nebraska Relay System at 711 or 800-833-7352 at least 2 weeks before the hearing date.

This section specifies the state's process to bring this waiver into compliance with federal HCB settings requirements.

The process to bring this waiver into compliance with federal home and community-based settings requirements is described in the state's statewide transition plan document posted on the DHHS public website at http://dhhs.ne.gov/developmental_disabilities/Documents/TransitionPlan.pdf. The statewide transition plan document is in a matrix format on the website and includes a summary, background information, the CMS HCBS rule, the transition plan requirements, and the final transition plan.

The Comprehensive Transition Plan Matrix, posted on the DHHS website identifies the task, regulatory compliance area, action item, the anticipated start date, the targeted completion date, Nebraska DHHS resources, stakeholders, and expected outcome.

The state will monitor HCBS settings on an ongoing basis as part of the established survey and certification process.

The Matrix specific to this waiver has been converted to plain text and contains exactly the same language contained in the December 1, 2014 submitted Statewide Transition Plan. This waiver-specific transition plan identifies the task, regulatory compliance area, action item, anticipated start date, targeted completion date for timelines to be accomplished, Nebraska DHHS resources, stakeholders, and expected outcome. Each action item, such as remediation strategies, includes the milestones, with beginning and end dates. All settings will be in full compliance with the regulation by March 17, 2019. The state will monitor HCBS settings on an ongoing basis as part of the established survey and certification process. When the state identifies settings that are not “community-like”, the state does not intend to provide evidence that the setting comports with the HCB Settings rule. The Division has a plan with an array of options to bring "not likely" day services settings into compliance that identifies the resources necessary and targeted timeframes for each element of the plan. For any settings that are not capable of coming into compliance, the Division has a plan to transition individuals to alternative services settings.

Nebraska 0394.R02.01 Waiver Transition Plan:

Information contained herein is taken directly from the Nebraska Statewide Transition Plan submitted on December 1, 2014; the following components are specific to the services provided in Nebraska’s 0394.R02.01, Adult Day Waiver. This plan is organized by task area, then regulatory compliance area. The action item numeration coordinates with the Statewide Transition Plan.

*Supplemental and Clarifying Information: Anywhere 'ongoing' is identified as a target completion date the action item will be met prior to March 17, 2019 and efforts are ongoing to meet or maintain compliance throughout the transition period.

Task: Identification

Regulatory Compliance Area: Community Integration - Day Services

Action Item #37: Identify regulation changes necessary to ensure day services compliance with new CMS HCBS rules.
Anticipated Start Date: 06/01/2014
Targeted Completion Date*: 12/31/2014
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, CMS Toolkit and Guidance, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison
Expected Outcome: Necessary changes to regulations are identified to comply with new CMS rules regarding day services

Action Item #:38: Identify internal Division guideline revisions necessary to ensure day services compliance with new CMS HCBS rules.
Anticipated Start Date: 06/01/2014
Targeted Completion Date*: 12/31/2014
Nebraska Health and Human Services Resources: DDD Guidelines and Related QI and Service Coordination Forms and Tools
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator, Technical Assistance Manager
Expected Outcome: Necessary changes to internal Division guidelines are identified to comply with new CMS rules regarding day services

Action Item #39: Identify day services settings that that are "likely not" community.
Anticipated Start Date: 10/01/2014
Targeted Completion Date*: 12/31/2014
Nebraska Health and Human Services Resources: Provider Listings, Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Provider Self-Assessments, Stakeholder Meetings

Nebraska Health and Human Services Stakeholders: QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: There is a list of day service locations that may be considered "not likely" community.

Action Item #40: Create Provider Self-Assessment Tool and revise existing Self-Advocate/Family Surveys to provide information regarding the community nature of day settings.
Anticipated Start Date: 08/15/2014
Targeted Completion Date*: 09/30/2014
Nebraska Health and Human Services Resources: Prior Self-Advocate/Family Surveys, Samples from Other States, CMS Toolkit, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Community Liaison, Technical Assistance Manager, DD Contract Manager
Expected Outcome: A Provider Self-Assessment Tool is created and the DD Community-Based Services Self-Advocate/Family Survey is updated to provide information regarding the community nature of day settings.

Regulatory Compliance Area: General or Other Requirements

Action Item #45: Review regulations, internal guidelines, and HCBS waivers to identify requirements and language that don't comport with all other requirements of the new CMS HCBS rules that are not already identified herein.
Anticipated Start Date: 07/10/2014
Targeted Completion Date*:12/31/2014
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, DDD Operational Guidelines, Nebraska's DD HCBS Waivers, CMS Toolkit and Guidance, Stakeholder Meetings and Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator, Technical Assistance Manager, Community Liaison
Expected Outcome: Necessary changes to NAC, waiver language, policy and procedures are identified to ensure compliance with lease requirements and roommate choice provisions of the new CMS HCBS rules

Action Item #46: Identify data sources and performance metrics that relate to and/or demonstrate the current level of compliance with new CMS rules
Anticipated Start Date: 07/10/2014
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Quality Review Team Surveys, Quality Improvement Indicators/Data, CMS Toolkit, Stakeholder Meetings, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: QI Team, Community Liaison, Service Coordination Leadership Team, Quality Review Teams
Expected Outcome: Valid and reliable data produce a performance metric that demonstrates compliance with new CMS rule requirements

Action Item #47: Identify data sources that will be used to measure transition plan activities compliance with new CMS rules
Anticipated Start Date: 10/01/2014
Targeted Completion Date*: ongoing
Nebraska Health and Human Services Resources: HCBS Compliance Plan Matrix (and all related data sources referenced therein), Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator
Expected Outcome: Valid and reliable data produce a performance metric that can be used to assess the success of transition plan actions in meeting the expectations of the new CMS rule requirements

Task: Analysis

Regulatory Compliance Area: Community Integration – Day Services

Action Item #48: Distinguish "likely not" community day services settings that meet requirements of heightened scrutiny from those that do not.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Provider Self-Assessments, Stakeholder

Meetings
Nebraska Health and Human Services Stakeholders: QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: For community day services, the Division knows which services are fully compliant, which ones are not fully compliant but meet the heightened scrutiny requirements, and is aware of the location and characteristics of settings that are not compliant and do not meet the heightened scrutiny requirements. By fully analyzing the characteristics of the various settings, the Division is better equipped to consider options to obtain full compliance.

Action Item #49: Consider remediation options for "likely not" community day settings that do not meet requirements of heightened scrutiny.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Provider Self-Assessments, Stakeholder Meetings (led by Consultant, to include providers, self-advocates/families, service coordinators and advocacy entities)
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison, QI Team
Expected Outcome: The Division has a plan with an array of options to bring "not likely" day services settings into compliance that identifies the resources necessary and targeted timeframes for each element of the plan. For any settings that are not capable of coming into compliance, the Division has a plan to transition individuals to alternative services settings.

Action Item #50: Draft regulation changes necessary to ensure compliance with new CMS HCBS Rules related to day settings.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:03/31/2016
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404 and Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Technical Assistance Team, Community Liaison
Expected Outcome: Regulations comply with the new CMS HCBS rules related to day settings and support DDD activities to ensure compliance

Action Item #51: Draft internal Division guideline revisions necessary to ensure compliance with new CMS HCBS rules related to day settings
Anticipated Start Date: 01/01/2015
Targeted Completion Date*:03/31/2016
Nebraska Health and Human Services Resources: DDD Guidelines and Related QI and Service Coordination Forms and Tools
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator, Technical Assistance Manager
Expected Outcome: DDD internal staff guidelines comply with the new CMS HCBS rules related to day settings and support QI Team and Service Coordination Team activities to ensure compliance.

Action Item #52: Review and revise day service definitions to remove reference to facilities-based settings and clarify the Division's mission of serving all individuals in the most integrated setting possible.
Anticipated Start Date: 06/01/2014
Targeted Completion Date*:10/01/2014
Nebraska Health and Human Services Resources: Developmental Disabilities HCBS Waivers, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, DD Waiver Administrator
Expected Outcome: DD HCBS Waivers reflect language that describes the Division's mission to serve all individuals in the most integrated setting possible.

Action Item #53: Review and revise retirement services definition, requirements and restrictions.
Anticipated Start Date: 11/01/2014
Targeted Completion Date*:12/31/2015
Nebraska Health and Human Services Resources: Developmental Disabilities HCBS Waivers, Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, DD Waiver Administrator
Expected Outcome: Retirement services are clearly defined to include requirements and restrictions.

Regulatory Compliance Area: General or Other Requirements

Action Item #58: Analyze other regulations and internal guidelines not specifically addressed in HCBS Transition Plan to determine whether additional revisions and/or enhancements are needed to ensure compliance with HCBS rule. If revisions are warranted, a plan for implementation is to be created.

Anticipated Start Date: 11/01/2014
Targeted Completion Date*:06/30/2015
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, DDD Guidelines, CMS Toolkit and Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: Division regulations and guidance have been fully reviewed and revised to ensure requirements with all new HCBS rules.

Action Item #59: Analyze performance metrics used to assess the current level of compliance with new CMS Rules; revise where necessary to address new requirements.
Anticipated Start Date: 10/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Quality Review Team Surveys, Quality Improvement Indicators/Data
Nebraska Health and Human Services Stakeholders: QI Team, Community Liaison, Service Coordination Leadership Team, Quality Review Teams
Expected Outcome: Performance metrics will demonstrate the level of existing system compliance with new HCBS rules and identify areas where enhanced effort is needed to ensure individuals are being supported in the most integrated way possible.

Action Item #60: Analyze performance metrics and revise where necessary to ensure compliance with all elements of the transition plan (including any new elements that are identified in the Identification and Analysis activities described herein.)
Anticipated Start Date: 10/01/2014
Targeted Completion Date*:05/31/2016
Nebraska Health and Human Services Resources: HCBS Compliance Plan Matrix (and all related data sources referenced therein), Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of CBS, Service Coordination Team Administrator, QI Administrator
Expected Outcome: Performance metrics will demonstrate the level of compliance with the expectations contained within the transition plan.

Regulatory Compliance Area: Individual Rights

Action Item #64: Enhance survey tools and process to more rigorously review human and legal rights processes.
Anticipated Start Date: 10/01/2014
Targeted Completion Date*:05/31/2016
Nebraska Health and Human Services Resources: Service Coordination Monitoring Tools, Provider Site Reviews and Compliance Surveys
Nebraska Health and Human Services Stakeholders: QI Team, Service Coordination Leadership Team
Expected Outcome: DDD regulations ensuring that individual's rights are not improperly restricted are diligently enforced.

Task: Outreach

Regulatory Compliance Area: Plan Creation and Implementation

Action Item #1: Draft a waiver transition plan.
Anticipated Start Date: 07/01/2014
Targeted Completion Date*:09/01/2014
Nebraska Health and Human Services Resources: Nebraska Administrative Code, HCBS Waivers, DHHS Internal Policies and Procedures, CMS Toolkit and Guidance, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: DD Director, MLTC HCBS Administrator, Deputy Director of DD Community Based Services, MLTC Waiver Manager and other Waiver Team Staff, DD Waiver Administrator, DD Operations Administrator, DD QI Administrator, DD Technical Assistance Manager, DD Community Liaison
Expected Outcome: A comprehensive waiver transition plan is drafted that proposes actions necessary to ensure compliance with the new CMS HCBS rules, relevant timelines, resources, stakeholders, and expected outcomes. The transition plan is comprehensive, but is also severable by applicable waiver - so that, if necessary, the plan may be finalized in stages by waiver.

Action Item #2: Make the waiver transition plan available for public comment.
Anticipated Start Date: 09/03/2014

Targeted Completion Date*:10/15/2014
Nebraska Health and Human Services Resources: DHHS Website, Omaha World Herald Newspaper Announcement, Direct Mailing to DD Service Participants, Direct Outreach to Providers
Nebraska Health and Human Services Stakeholders: DHHS MLTC and DDD Staff
Expected Outcome: The draft comprehensive waiver transition plan is distributed via multiple mediums to engage and gather public comment for a time period to exceed 30 days.

Action Item #3: Coordinate and hold public meetings.
Anticipated Start Date: 08/01/2014
Targeted Completion Date*:10/15/2014
Nebraska Health and Human Services Resources: Transition Plan, PowerPoint Presentations, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: DHHS MLTC and DDD Staff
Expected Outcome: Stakeholders are able to attend public meetings where the new HCBS requirements are discussed and where they may participate in verbal comment and present questions related to the draft transition plan.

Action Item #4: Review, incorporate, and respond to public comments.
Anticipated Start Date: 09/25/2014
Targeted Completion Date*:11/01/2014
Nebraska Health and Human Services Resources: Transition Plan, Public Comment (in person, via email, telephonic, and fax/mail), DHHS Website, Direct Mailing to Waiver Participants, CMS Toolkit, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: DHHS MLTC and DDD Staff
Expected Outcome: All public comments are considered, responses thereto are prepared and distributed with the finalized plan; if DHHS deems necessary, the transition plan may be modified due to public comment.

Action Item #5: Finalize transition plan for submission to CMS, either comprehensively or separately by specific waiver.
Anticipated Start Date: 10/15/2014
Targeted Completion Date*:11/15/2014
Nebraska Health and Human Services Resources: Transition Plan, Public Comment (in person, via email, telephonic, and fax/mail), DHHS Website, Direct Mailing to Waiver Participants, CMS Toolkit, Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: DHHS MLTC and DDD Staff
Expected Outcome: Submit for CMS approval a comprehensive transition plan to include a summary of and response to public comments.

Regulatory Compliance Area: Community Integration – Day Services

Action Item #65: Identify and implement effective strategies for involving stakeholders in the analysis and remediation of "not likely" community day services settings
Anticipated Start Date: 06/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Public Meetings, Specialized Provider Workgroup/Meetings, Coordination with the ARC of Nebraska, People First of Nebraska, the Developmental Disabilities Council, and the Developmental Disability Advisory Committee, Nebraska Association of Service Providers, and Transition Plan Consultant
Nebraska Health and Human Services Stakeholders: Deputy Director of Community Based Services, Community Liaison, Technical Assistance Manager
Expected Outcome: Stakeholders including self-advocates and their families and friends, providers, and self-advocacy entities will guide and inform the "not like" community day services changes.

Regulatory Compliance Area: Community Integration – General or Other Requirements

Action Item #67: Share information with individual and their families/guardians, service providers, and advocacy entities on the requirements of the new CMS HCBS rules and the changes they can expect to see as a result of implementation.
Anticipated Start Date: 07/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Transition Plan, DHHS Website, Direct Mailing to Individuals in Services, Articles in the Sower Newsletter, Public/Stakeholder Meetings
Nebraska Health and Human Services Stakeholders: DD Director, Deputy Director of Community Based Services, Waiver Administrator, Operations Administrator, QI Administrator, Technical Assistance Manager, Community Liaison
Expected Outcome: All stakeholders understand the requirements of the new CMS HCBS rules, what they can expect, and how their services will be impacted.

Task: Remediation - DUE TO CHARACTER LIMITATION IN ATTACHMENT A-2 PLEASE SEE MAIN B. ADDITIONAL NEEDED INFORMATION OPTIONAL SECTION

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

CONTINUED FROM ATTACHMENT A-2:

Task: Remediation

Regulatory Compliance Area: Community Integration – Day Services

Action Item #68: Provide education, technical assistance and enforcement of regulatory changes to day services requirements that align with new CMS HCBS rules related to day services settings. This includes enforcement of progressive discipline to include financial penalties and failure to renew certification for specialized providers.
Anticipated Start Date: 01/01/2017
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Nebraska Administrative Code, Title 404, Provider Site Reviews and Compliance Surveys, Provider Training and Technical Assistance, Service Coordination Monitoring Tools, Service Coordination Individual/Family Meetings
Nebraska Health and Human Services Stakeholders: Deputy Director of Community Based Services, QI Team, Technical Assistance Team, Service Coordination Team, Community Liaison
Expected Outcome: The Division will exercise its authority to ensure compliance with new CMS HCBS rules related to community like day services settings

Action Item #69: Seek and secure resources to support innovation necessary to bring "not likely" community day services settings into compliance with new CMS HCBS rules. This includes evaluation of rate methodology to account for increased provider staffing requirements to support individuals in a more integrated setting.
Anticipated Start Date: 01/01/2016
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: 2017-18 Biennial Budget Request to Nebraska Legislature, Developmental Disability Council Grants, and other State/Federal Grants or Funds
Nebraska Health and Human Services Stakeholders: DD Director, Deputy Director of Community Based Services, Technical Assistance Manager, DD Fiscal Analyst
Expected Outcome: "Not likely" community day services settings that don't meet the requirements under heighten scrutiny have accessed resources and implemented changes necessary to be compliant with the new CMS HCBS rules

Action Item #70: Reach out to integrated providers of retirement services to increase options available to retirees in developmental disability services. While this may affect both day and residential services, efforts are targeted towards day services as that is where the Division recognizes the greatest risks.
Anticipated Start Date: 01/01/2015
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Aged and Disabled Programs, Leagues of Human Dignity, State and Local Chambers of Commerce, State and Local Organizations Targeted at Retirees, Stakeholders, Advocacy Entities
Nebraska Health and Human Services Stakeholders: Technical Assistance Team, Community Liaison, QI Manager, Contract Manager
Expected Outcome: An array of service provider are available to support individuals with developmental disabilities throughout Nebraska to avoid unnecessary institutionalization or other services that may exclude individuals from integrated community enjoyment.

Regulatory Compliance Area: General or Other Requirements

Action Item #73: Routinely re-evaluate monitoring tools and processes for all services settings to ensure continued compliance with requirements mandated by the new CMS HCBS rules. This includes site characteristic issues, individual rights, and all other aspects relevant thereto.
Anticipated Start Date: 07/01/2017
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Provider Site Reviews and Compliance Surveys, Participant Experience Surveys, Self-Advocate/Family Surveys, Service Coordination Monitoring Tools, Provider Self-Assessments, Stakeholder

Meetings
Nebraska Health and Human Services Stakeholders: QI Team, Technical Assistance Team, Community Liaison, Service Coordination Leadership Team
Expected Outcome: HCB services support access to the greater community, offers opportunities for employment, optimizes independence, facilitates choice and ensures individual rights are protected.

Action Item #74: Routinely review and revise Service Coordination hiring tools, orientation, training curriculum, monitoring tools and other supports to ensure a continued focus on person centered practices, recognition of and advocacy for individual rights, and ensuring that all individuals are supported in the most integrated settings possible.
Anticipated Start Date: 03/01/2015
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Service Coordination Hiring Tools and Orientation Curriculum, Service Coordination Training Curriculum, Service Coordination Monitoring Tools, Service Coordination Recognition Programs, Service Coordination Performance Evaluation Tools, Service Coordination Individual/Family Meeting Tools (including Personal Focus Worksheets and other planning tools), Annual State-Wide Service Coordination Training and Tri-Annual Developmental Disability Conferences
Nebraska Health and Human Services Stakeholders: Deputy Director of Community Based Services, Service Coordination Leadership Team, Technical Assistance Team
Expected Outcome: Service coordinators have the skills and tools to facilitate planning that reflects individual needs and preferences and conduct plan monitoring to ensure individual rights, optimize independence, facilitate choice and maximize opportunities to access community and receive services in the most integrated setting

Action Item #75: Provide an annual update regarding this Transition Plan in the Division of Developmental Disabilities Update provided to the Nebraska Legislature and available to Stakeholders.
Anticipated Start Date: 03/15/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Annual Division of Developmental Disabilities Update
Nebraska Health and Human Services Stakeholders: DD Director, Deputy Director of Community Based Services
Expected Outcome: The Division is accountable to the Nebraska Legislature and all stakeholders for ensuring compliance with the HCBS rules ensuring that all individuals have access to and are being served in the most integrated setting.

Regulatory Compliance Area: Individual Rights

Action Item #76: Provide additional training to individual and their families, service providers and Division staff in the area of right restrictions/ensuring individual rights are protected.
Anticipated Start Date: 09/01/2014
Targeted Completion Date*: Ongoing
Nebraska Health and Human Services Resources: Technical Assistance and Service Coordination Training Curriculum, Nebraska Association of Service Provider Meetings, the Sower Newsletter, and Individual/Family Meeting
Nebraska Health and Human Services Stakeholders: Technical Assistance Team, Contract Manager, Community Liaison, Service Coordination Team
Expected Outcome: All stakeholders understand the conditions under which and the requirements that must be met before an individual's rights are restricted; all stakeholders appreciate, recognize and diligently protect the rights of all individuals receiving services.

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
Division of Developmental Disabilities
(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
a) The functions performed by that division/administration:
DDD performs participant waiver enrollment activities; management of approved limits; monitoring of expenditures; level of care evaluations; review of participant service plans; prior authorization of waiver services; utilization management; qualified DD provider agency certification; execution of Medicaid provider agreements; establishment of statewide rate methodology; establishment of rules, policies, and procedures governing the waiver program; and quality improvement activities.

b) The document utilized to outline the roles and responsibilities related to waiver operation:
The Nebraska State Medicaid Plan Section 1, Citation 1.1(a) outlines designation and authority and was approved by CMS November 29, 2007, with an effective date of July 1, 2007.

c) The methods that are employed by the designated State Medicaid Director in the oversight of these activities:
The State Medicaid Director is the Director of the Division of Medicaid and Long Term Care (DMLTC) within the Department of Health and Human Services. Designated staff within DMLTC reviews reports of provider non-compliance and coordinates corrective action measures with DDD as necessary and appropriate; prepares or reviews statistical and financial data for CMS reports in collaboration with DDD and financial services staff; attends the DDD Quality Improvement (QI) Committee meetings as an active participating member; meets with DDD staff to review program and client issues as necessary and appropriate; tracks the use of Medicaid funding on the use of waiver funding relative to the budgeted amounts; and monitors expenditures and budget projections; reviews the development, renewal, or amendments of HCBS waivers and has final approval and electronic submittal authority; reviews the cost neutrality formulas developed in collaboration with DDD and financial services staff; and submits claims for federal funds for allowable activities administered or supervised by DDD.

The frequency of the oversight is related to the oversight activity or collaborative projects and tasks, and ranges from monthly budget activities to annual reporting activities.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

   Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency
Participant waiver enrollment	☑
Waiver enrollment managed against approved limits	☑
Waiver expenditures managed against approved levels	☑
Level of care evaluation	☑
Review of Participant service plans	☑
Prior authorization of waiver services	☑
Utilization management	☑
Qualified provider enrollment	☑
Execution of Medicaid provider agreements	☑
Establishment of a statewide rate methodology	☑
Rules, policies, procedures and information development governing the waiver program	☑
Quality assurance and quality improvement activities	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of Division of Developmental Disabilities (DDD) QI committee meetings, the total number of meetings in which a representative of the Division of Medicaid and Long Term Care (MLTC) participated.

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Of the total number of certified providers reviewed each calendar year, the number of providers that maintained their certification.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
DD Surveyor Consultant certification tracking - Excel

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Nebraska Department of Health and Human Services is the Single State Medicaid Agency. The DHHS Chief Executive Officer has delegated the functions of the Single State Medicaid Agency to the State Medicaid Director in the Division of Medicaid and Long Term Care Services. The State Medicaid Director has the ultimate authority for all of Nebraska's Medicaid services.

The DHHS DDD Quality Improvement efforts for Community Based Services are coordinated through the DDD QI Committee (QIC) comprised of representatives from DDD Central Office, DHHS Medicaid, and DDD Service Coordination. The DHHS Licensure Unit provides aggregate data as requested. The QIC meets quarterly and reviews aggregate data for statewide monitoring, incidents, complaints, investigations, and certification and review surveys, to identify trends and consider statewide changes that will support service improvement. The Committee also reviews data and reports on subjects, including, but not limited to:

- HCBS waiver service requirements
- Licensure Unit investigations
- Quality Review Team activities, and
- Service utilization information.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QIC, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes show review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

The QIC receives reports and information and provides/shares feedback and support to the service districts. The MLTC representative verbally reports activities of the QIC to his/her administrator and/or the Medicaid Director and makes all meeting minutes and reports available for his review.

A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

The Division's quality assurance efforts include a Continual Quality Improvement (CQI) system to effectively monitor community-based placements and programs with appropriate protections, services, and supports. This is partially accomplished through active monitoring for individuals in services through local Service Coordination offices.

In order to assure protections, services, and supports on a systems level, the Division has established a formal certification and review process in accordance with state regulations, contract specifications, and state waiver requirements for provider agencies providing specialized services. This certification process includes certification and service reviews of community-based providers and programs by DDD Surveyor/Consultants, who are scheduled to visit providers in accordance with the initial provisional, 1-year, or 2-year certifications issued by the Division. The purpose of the reviews is to identify gaps and weaknesses, as well as strengths, in specialized services provided on a statewide level. In order to ensure continued certification as a provider of DD specialized services, a formal plan of improvement is required to ensure remediation of review findings that need to be addressed. On an ongoing basis, incidents and complaints associated with certified providers which have been reported to the Division are reviewed and appropriate levels of follow-up are conducted.

The DD Division QI operational framework and procedures are as follows:

A. PDSA (Plan, Do, Study, Act) for testing changes to the QI Data Collection Process:

1. Plan
• What is Being Measured?
• Why is it Being Measured?
• What is the Data Source?
• Who is Responsible?

2. Do
• What Will Be Done and
• How Frequently Will It Be Done?
• How Will Data Be Collected
• Who Will Collect the Data?
• How/Who Will Aggregate the Data and Generate Reports?
• In What Format Will Data Be Reported?

3. Study
• Who/When Will Results be Reviewed and Interpreted?
• To Whom Will Recommendations be Made/Timeframes?

4. Act
• Who Will Implement/Over-See Recommended Changes?

B. Reporting Data

1. Process of Aggregating Data and Monitoring Data Trends
Data are aggregated through queries from systems where data are entered directly by the worker or reporter. These systems include
• Info Path,
• SAS,
• N-FOCUS,
• Therap,
• SharePoint, and
• OnBase.

For data that are not entered directly into a system, data are derived from individual source documents such as audits of files or certification reports and manually tabulated as necessary.

2. Report Formats
Reports reflect information via graphs, tables, and narratives. QIC minutes display meeting topics and discussion, as well as action plans or follow-up categorized by performance measures.

C. Communicating Results
Aggregate data are shared through the QIC with DD Administrative staff, Service Coordination, and other stakeholders. Data reports are submitted as requested to CMS representatives and the Department of Justice Independent Expert.

D. Using Data for Implementing Improvement
Data are reviewed on at least a quarterly basis through the QIC and DD Administration. Appropriate recommendations, action plans, and follow-up are included within the QIC minutes.

E. Assessment of the Effectiveness of the QI Process
Contributors to the assessment of the QI process can be determined through CMS audit and onsite visit reports and findings. In addition, effectiveness is also measured through the relevancy that collected data have in providing useful information on the timeliness and quality of services provided through Community Based services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Under the area of administrative authority, individual problems are not discovered.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the*

selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☑ Intellectual Disability or Developmental Disability, or Both					
	☑	Autism	21		☑
	☑	Developmental Disability	21		☑
	☑	Intellectual Disability	21		☑
☐ Mental Illness					
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

To be eligible for waiver services, the individual must meet additional criteria -

The individual must not receive services under another 1915 (c) home and community based services waiver.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to

that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*.

The limit specified by the State is *(select one)*

- **A level higher than 100% of the institutional average.**

  Specify the percentage:

- **Other**

  Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  The cost limit specified by the State is *(select one)*:

  - **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
  - **The following percentage that is less than 100% of the institutional average:**

    Specify percent:

  - **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	1400
Year 2	1470
Year 3	1540
Year 4	1610
Year 5	1680

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

◉ **Not applicable. The state does not reserve capacity.**

○ **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Waiver capacity will be allocated statewide. Individuals who meet waiver eligibility criteria listed at Appendix B-1-a and B-1-b of this waiver application, will be given a waiver slot.

In the event that all slots were filled, the state would immediately submit an application to increase available slots to serve all eligible individuals.

All eligible individuals have comparable access to all services offered in this waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ◉ **SSI Criteria State**
   - ○ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ◉ **No**
   - ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☑ **Optional State supplement recipients**
- ☑ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ◉ **100% of the Federal poverty level (FPL)**
  - ○ **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- ☑ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☑ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☑ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

All other mandatory and optional groups under the plan are included.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

◉ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

  Specify the percentage:
- ○ **A dollar amount which is less than 300%.**

  Specify dollar amount:
- ◉ **A percentage of the Federal poverty level**

  Specify percentage: 100
- ○ **Other standard included under the State Plan**

  Specify:

- ○ **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The following formula is used to determine the needs allowance:**

  Specify:

- ○ **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable**
- ○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

  Specify:

  Specify the amount of the allowance (*select one*):

  - ○ **SSI standard**
  - ○ **Optional State supplement standard**
  - ○ **Medically needy income standard**
  - ○ **The following dollar amount:**

    Specify dollar amount: If this amount changes, this item will be revised.
  - ○ **The amount is determined using the following formula:**

    Specify:

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ◉ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:
- ○ **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ◉ **A percentage of the Federal poverty level**

  Specify percentage: 100
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The State does not establish reasonable limits.**
- ○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

A Disability Services Specialist (DSS) performs the initial evaluation of level of care. A DSS is required to have a Bachelor's Degree in psychology, social work, education, public administration, or a related human service field, and one year experience of working in the field of developmental disabilities. They must be able to communicate effectively verbally and in writing, possess excellent interpersonal skills, function as a team leader and team member, work independently, and organize/manage workload. Experience in working with people with DD and knowledge of quality assurance/improvement is preferred, but is not a requirement.
They must have knowledge of current practices in the field of DD, including service coordination, person-centered planning, ADA standards, self-direction, community integration, the theory of normalization, and provision of habilitation services.

The following abilities are required: Communicate effectively in a variety of situations; develop working relationships with individuals with DD, their families, community professionals, and other groups of individuals with interests in DD; and summarize and analyze information to make decisions by deduction.

Skills in interviewing techniques, assessing skills, abilities, personal goals, and needs and explaining services to individuals, families, and guardians are required.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

DHHS-DDD applies the following criteria to determine the need for ICF-DD services:

1. The individual, as documented in an evaluation or evaluations, completed no more than three years before the initial determination of Waiver eligibility, has an intellectual disability or has a severe, chronic disability other than

intellectual disability or mental illness which:
A. Is attributable to a mental or physical impairment other than a mental or physical impairment caused solely by mental illness;
B. Is manifested before the age of 22 years;
C. Is likely to continue indefinitely; and
D. Results in:
In the case of a person three years of age or older, a substantial limitation in three or more of the following areas of major life activity, as appropriate for the person's age:
(a) Self-care;
(b) Receptive and expressive language development and use;
(c) Learning;
(d) Mobility;
(e) Self-direction;
(f) Capacity for independent living; and

2. The individual can benefit from habilitation directed toward-
A. The acquisition, retention, and improvement of self-help, socialization, and adaptive skills for the individual's maximum possible independence; or
B. For dependent individuals where no further positive growth is demonstrable, the prevention of regression or loss of current optimal functional status.

The Developmental Index is the LOC instrument that is utilized.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The instruments used to evaluate LOC for waiver eligibility is comparable to the assessment tools completed for institutional placement. The instruments note skills, abilities, personal goals, and needs, and the services and supports needed to address the individual's personal goals and needs. Provider staff, family members, or others who are familiar with the individual participate in the completion of the applicable tool.

The Developmental Index differs from the ICF-DD LOC tool by assessing skills, abilities, and areas needing improvement for maximizing independence in the community, such as job-readiness, managing personal finances, and accessing community services.

If a former waiver participant enters the State ICF-DD for short-term intensive behavioral treatment, the LOC is determined using the ICF-DD LOC assessments. The outcome of the determinations yielded from the Developmental Index is similar to the outcome of determinations yielded from the assessment completed for institutional placement.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The SAME process for evaluation and revaluation for the need for ICF-ID level of care is as follows:

The Division of Developmental Disabilities currently employs 19 Disability Services Specialists, located across the state to determine initial eligibility prior to the participant's entry into waiver services, and to complete an annual review of eligibility for HCBS waiver for adults with intellectual or developmental disabilities.

The following information is made available to the DSS:
1. Psychological evaluation or evaluations completed no more than three years before the initial determination of waiver eligibility.

2. Physical evaluation current within 1 year of initial eligibility and annually thereafter, unless waived by their

physician.

3. Individual service plan. The service plan must identify the needs and personal goals of the individual and specify how those needs will be addressed. The service plan identifies the individual's personal and career goals, DD services and supports, as well as services and supports to be provided by other non-DDD funded resources (including medical services and supports). The annual service plan documentation requires identification of DD provider(s); waiver services; authorized funding amounts and/or units of services; and teaching and supporting strategies to meet the individual's health and safety needs and personal goals. The service plan is developed by an interdisciplinary team consisting of the individual; the assigned DDD Service Coordinator; legal representative; family, if the individual chooses; specialized provider staff; and non-specialized providers, other professionals, advocates, and/or friends as requested by the individual or legal representative. The service plan is reviewed initially and annually thereafter.

4. Developmental Index current within one year of initial eligibility and within one year of annual review of eligibility. The Developmental Index is specific to waiver eligibility and identifies an individual's skills, abilities, and areas needing improvement. The Developmental Index is completed by the individual's Service Coordinator and provider staff and reviewed at the service plan meeting. If there are discrepancies between/among the assessments, these discrepancies must be clarified in the service plan.

The DDD service coordinator notifies the DSS when the above eligibility information is available electronically. The DSS verifies Medicaid eligibility, and reviews the information to determine whether the individual meets ICF-DD level of care criteria.

The DSS looks at the individual's assessed abilities and needs; how the assessed needs are being met, including DD services, Medicaid State Plan services, generic non-Medicaid community services and supports, and family supports, and considers whether the individual would require the services of an ICF-DD if HCBS waiver was not available. The individual or legal representative is given the choice between home and community based waiver services and ICF-DD services and the choice and consent to receive waiver services is documented on a form. The DSS prior approves waiver eligibility if HCBS waiver is chosen.

Annually, the DSS reviews the annual service plan, the Developmental Index (LOC assessment tool), verifies Medicaid eligibility, and verifies the completion of a physical evaluation. The DSS completes a Waiver Eligibility Determination worksheet on SharePoint, and at any point, the DSS may ask for additional information and clarification.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

DD staff use the following procedures and processes to ensure timely reevaluations of level of care: Tickler methods, such as Excel spreadsheets and electronic alerts, and the processes that are components of internal policy directives.

Designated DD staff review each electronic waiver eligibility determination worksheet as well as aggregate data to ascertain compliance with established timelines.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The DDD Disabilities Services Specialists, who are responsible for the performance of evaluations and reevaluations of level of care, maintain a separate record for each waiver participant. The records are maintained electronically by the disability services specialist, as well as in SharePoint electronic libraries maintained by DHHS.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of initial waiver eligibility determinations that were completed, the number of initial waiver eligibility determinations that were completed within ten business days of receipt of all required information.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination worksheet - SharePoint

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: With each waiver eligibility determination	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Of the total number of annual LOC re-determinations that were completed, the number of annual LOC re-determinations that were completed within 395 days of their initial LOC evaluation and within 395 days of their last annual LOC evaluation.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination Worksheet - SharePoint

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: With each waiver LOC redetermination.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of initial LOC determinations, the number of initial LOC determinations that were completed prior to the entry into waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination Worksheet – SharePoint, Therap, and NFOCUS. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: With each waiver eligibility determination	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Annual redetermination of eligibility is completed for all (100%) waiver recipients. The annual review of LOC is a collaborative effort that includes a number of DD staff. DD service coordination staff ensure that required information is available to the DSS. Service Coordinators (SC), SC Supervisors, Disability Services Specialist (DSS), and DSS Supervisors use the following procedures and processes to ensure timely reevaluations of level of care: Tickler methods, such as Excel spreadsheets and electronic alerts, and the processes that are components of internal operational guidelines and protocols.

The timeline for completion of the initial and annual waiver determination by the DSS is within ten business days of receipt of all required information. The waiver participant's SC notifies the DSS when all the information is available to the DSS. Annually, the DSS reviews the annual service plan, the Developmental Index (LOC assessment tool), verifies Medicaid eligibility, verifies the completion of a physical evaluation, and completes a Waiver Eligibility Determination worksheet on SharePoint.

Designated DD staff review each electronic waiver eligibility determination worksheet as well as aggregate data to ascertain compliance with established timelines.

The monitoring process to measure compliance with the above Sub Assurances consists of the DSS Supervisor reviewing a minimum of 10% of the DSS files for compliance with timelines, required paperwork, and whether the eligibility determinations are appropriate. The DSS Supervisor reviews the files and completes the "Annual Supervisory Waiver QA File Review."

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The state monitors level of care decisions and takes action to address inappropriate LOC determinations, which may include failure to determine eligibility, failure to determine eligibility within established timelines, inaccurate determinations, and missing or incomplete documentation. The state monitors the performance of the disability services specialists through self-measurement and look-behind reviews by their Supervisor. The following performance measurements are built into the SharePoint Waiver Eligibility Determination worksheet for each initial eligibility determination:

The DSS enters the date that all required information received.
The DSS enters the date that eligibility was determined.
The SharePoint system calculates the number of days between information received and eligibility determined.
The DSS enters YES or NO for Eligibility Review completed within 2 weeks of all information being received.

Designated DD staff review each electronic waiver eligibility determination worksheet and indicate whether the LOC determination was completed accurately. Aggregated data is evaluated to ascertain compliance with established timelines, for identification of technical assistance/training needs, and for identification of systems changes.

Monthly quality assurance reports are reviewed at the local level to ensure continued Medicaid and waiver eligibility for participants. The monthly quality assurance reports are generated by NFOCUS, Nebraska's electronic Medicaid eligibility system, and posted on an intra-agency website for access by DDD staff. Reports of annual physical evaluation dates are created from Therap, which is an electronic case management, authorization, and billing system utilized by DDD. DSSs, DD service coordinators, and SC Supervisors review applicable reports and take appropriate action as needed on individual cases. Examples of such action may be assisting the individual with recertification of Medicaid, scheduling an evaluation, creating and approving a service authorization to change or end services, determining waiver eligibility for new Medicaid recipients, etc.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. *informed of any feasible alternatives under the waiver; and*
ii. *given the choice of either institutional or home and community-based services.*

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Nebraska waiver participants are afforded choice between waiver services and institutional care.

Choice of ICF or waiver services is documented on Form DDD-1, the waiver consent form. Information about Nebraska's DD waiver services, feasible alternatives, and freedom of choice is provided verbally and in written materials to assist the individual or legal representative in understanding waiver services, funding of his/her services, and the roles and responsibilities of the participants (the individual, family, guardian, DHHS staff, etc.). Nebraska's DD waivers are posted on the public website as well as information and links to alternative DHHS and community services and supports. Information is also provided verbally and in writing by the participant's Service Coordinator or DD central office staff.

A signature for consent, documenting that waiver participant's choice is to receive community based waiver services over services in an institutional setting, is obtained upon initial determination of waiver eligibility and is kept in the individual's waiver file. Form DDD-1 explains the right and process to appeal.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Form DDD-1, the waiver consent form, is kept in the individual waiver file maintained by the Disability Services Specialist. The records are maintained electronically by the disability services specialist, as well as in SharePoint electronic libraries maintained by DHHS.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The following methods are utilized to provide meaningful access to services by individuals with limited English proficiency at entrance to waiver services and on and ongoing basis;
• Oral language assistance services such as interpreters;
• Translation of written materials, such as applications, brochures, due process, and the Notice of Decision;
• Foreign language placards, posters, etc.;
• Second language hiring qualifications; and
• Availability of translators, including sign language.

Foreign language web sites have been developed or are in the development stages.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	Day Habilitation		
Statutory Service	Integrated Community Employment		
Statutory Service	Respite		
Other Service	Assistive Technology and Supports (ATS)		
Other Service	Community Living and Day Supports (CLDS)		
Other Service	Home Modifications		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Retirement Services		
Other Service	Supported Integrated Employment		
Other Service	Team Behavioral Consultation		
Other Service	Vehicle Modifications		
Other Service	Vocational Planning		
Other Service	Workstation		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Day Habilitation service is formalized training and staff supports that take place in a non-residential setting separate from the individual's private residence or other residential living arrangement. Day Habilitation service is scheduled activities, formalized training, and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Day Habilitation service may be provided to individuals that do not have a clear plan for employment and are therefore not currently seeking to join the general work force. Training activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice necessary to participate successfully in community living. Individuals receiving day habilitation service are integrated into the community to the greatest extent possible.

Day Habilitation service may be delivered in integrated community settings or in provider owned and operated settings for a portion of the typical workday. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Day Habilitation service is a continuous day service and staff support is continuous, that is, staff are present at all times the individual is present. Continuous day services are expected to be available for no less than seven hours per day. The provider may operate a location where individuals come to check-in prior to participating in integrated activities and/or to participate in a variety of daily activities related to greater community living. Provider owned and controlled settings also allow for individuals who are experiencing short-term medical or behavioral crisis to participate in activities that are outside the residence.

Day Habilitation may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Teaching and supporting activities are not job-task oriented but instead are directed at improvement of basic skills such as attention span and motor skills, and not explicit employment objectives.

The activities, services, supports, and strategies are documented in the service plan, and the frequency and duration for which the service is delivered will be based on the service plan. Day Habilitation service will focus on enabling the individual to attain or maintain his or her maximum functional level and must be coordinated with but may not supplant any physical, occupational, or speech therapies listed in the service plan. In addition, the services and supports may reinforce skills taught in therapy, counseling sessions, or other settings. This service also includes the provision of personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the service plan.

Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan.

For individuals with degenerative conditions, this service may include training and supports designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Meals provided as part of this service do not constitute a full nutritional regiment and as applicable, physical nutritional management plans must be implemented as documented in the service plan. This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Individuals that choose Day Habilitation service may also choose Community Living and Day Supports (CLDS), Vocational Planning service, Supported Integrated Employment, or Integrated Community Employment but these services may not be billed during the same period of the day. Daily rates are available for Day Habilitation service when the person receives this service for four or more hours. Hourly rates are also available for times when the individual might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75).

When this service is not delivered continuously/consecutively for four or more hours, it must be billed at an hourly rate. CLDS can only be billed at an hourly rate on days when no daily rate is billed for Day Habilitation. When Day Habilitation, Workstation habilitation, CLDS, Vocational Planning service, Supported Integrated Employment, or Integrated Community Employment are provided in one workday, the delivered services are

billed in hours.

Transportation may be provided between the individual's place of residence and the day service site or between day service sites (in cases where the individual receives habilitative (teaching and supporting) services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitative services. The cost of transportation between other service sites should be billed under those waiver services and not this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

Payment for this waiver service does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified community based DD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:
Agency
Provider Type:
Certified community based DD provider agency
Provider Qualifications

License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.
DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service, nursing plan of care, or the individual's medical practitioner; and

Not be the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Integrated Community Employment

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Integrated Community Employment (ICE) service is intermittent formalized training and staff supports - needed by an individual to acquire and maintain a job/position in the general workforce at or above the state's minimum wage, but not less than the customary wage and level of benefits paid by the employer of the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment in an integrated setting in the general workforce that meets personal and career goals, as documented in the individual service plan. ICE services are person-centered and team supported to address the individual's particular needs for ongoing or intermittent habilitation (teaching and supporting) throughout stabilization services and extended integrated community employment services and supports. ICE is an intermittent service staff support is provided when the services and supports are needed. ICE, as an intermittent service, can only be billed in half, quarter hours, or full hour increments. An hour of service equates to one clock hour.

ICE service includes habilitative (teaching and supporting) services, with activities and strategies that are outcome based and focused to sustain paid work by individuals and are designed to obtain, maintain or advance employment. Intensive direct training, teaching, and supporting will be designed to provide the individual with face to face instruction necessary to learn explicit work-related responsibilities and skills, as well as appropriate work behavior.

ICE service enables individuals, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Support may involve assisting the individual in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

ICE is primarily provided away from the home, in a non-residential setting, during typical working hours. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Discreet training activities and supports is allowed in preparation for leaving the place where the person lives. Intermittent face to face individualized habilitative teaching and supporting activities is provided to assist the individual in maintaining employment. Habilitative goals and strategies must be identified in the service plan and specify in a measurable manner, the services to be provided to meet the preferences and needs of the individual.

ICE may include a customized home-based business. ICE may be delivered in a customized home based businesses and is allowed in participant directed companion homes. ICE service does not include employment in group settings such as Workstation service, enclaves, classroom settings, or provider-owned and controlled day service settings. In addition, it does not include services provided in provider-controlled residential environments such as Group Homes or Extended Family Homes.

Stabilization is ongoing habilitative training, or teaching and supporting services and strategies needed to support and maintain an individual in an integrated competitive employment site or customized home-based employment. Stabilization services, supports, and strategies are provided when the staff intervention time required at the job site is 20% - 50% of the individual's total work hours. Staff intervention includes regular contacts with the individual or on behalf of the individual to determine needs, as well as to offer encouragement and advice. Staff is intermittently available as needed to the individual during employment hours. Goals and strategies needed for the individual to maintain employment must be identified in the individual plan.

Extended ICE service is provided to persons who need ongoing intermittent support to maintain employment and when the staff intervention time required at the job site is less than 20% of the individual's total work hours. The provision of extended ICE is limited to the work site, including home-based business sites. Staff supports must include at a minimum, twice monthly monitoring at the work site. Extended ICE service must identify the services and supports needed to meet the needs of the individual in the service plan.

Prior to learning to access transportation independently, transportation between the individual's place of residence and the employment site is a component of ICE and the cost of transportation is included in the rate paid to providers.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. This service is not available under a program funded under section 110 of the Rehabilitation

Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
Payments that are passed through to users of supported employment programs; or
Payments for training that is not directly related to an individual's integrated community employment service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Payment for this waiver service does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

ICE stabilization service requires at least 40 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue reimbursement at the ICE rate as long as the minimum total number of hours worked for the last three months (including the current month) is more than 120 hours of work (or an average of 40 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 40 hours of employment per month.

Extended ICE service is time limited. Extended ICE service requires at least 80 hours of work per month paid at minimum wage or a wage consistent with that earned by the general working population, whichever is higher. DHHS will continue payment for the extended ICE service as long as the minimum total number of hours worked for the last three months (including the current month) is more than 240 hours of work (or an average of 80 or more hours per month for those three months). Multiple jobs that meet the wage requirements may be worked to reach 80 hours of employment per month. The provider may claim extended ICE for up to 24 months in order for the individual to meet their personal and career goals.

Income from customized home-based businesses may not be commensurate with minimum wage requirements with other employment. No more than two individuals may participate in a home-based business at the same participant-directed companion home.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified community based DD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Integrated Community Employment

Provider Category:

Agency

Provider Type:
Certified community based DD provider agency
Provider Qualifications

License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.

DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service, nursing plan of care, or the individual's medical practitioner; and

Not be the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

09 Caregiver Support	09011 respite, out-of-home

Category 2: **Sub-Category 2:**

09 Caregiver Support	09012 respite, in-home

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite is the temporary, intermittent relief to the usual non-paid caregiver(s) from the continuous support and care of the individual to allow the caregiver to pursue personal, social, and recreational activities such as personal appointments, shopping, attending support groups, club meetings, and religious services, or going to entertainment or eating venues, and on vacations. Components of the respite service are supervision, tasks related to the individual's physical and psychological needs, and social/recreational activities. Respite is provided on a short-term basis because of the absence or need for relief of those unpaid persons who normally provide care for the individual. Respite may be provided in the individual's home and/or in the community in the provider's personal home or in a provider-operated or controlled residence. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite is available only to those individuals who live with their usual non-paid caregiver(s). The term "usual non-paid caregiver" means a person who resides with the individual, is not paid to provide services, and is responsible on a 24-hour per day basis for the care and supervision of the individual.

Payment for respite does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

Respite service cannot be used as adult/child care while the parents work or attend school.

The amount of units for respite service is not determined using the objective assessment process. Respite is purchased within the individual's approved annual budget up to 30 days per waiver year or 240 hours, and is purchased as an individual budget amount prior to authorizing other specialized or non-specialized services.

Respite cannot be provided by members of the individual's immediate household.

All waiver services and providers must be prior authorized within the following guidelines:
1. The tasks and interventions to be performed to meet the needs of the individual are documented in the service plan.
2. For respite, a unit is defined as an hour, or if eight or more hours are provided in a calendar day, a day. Respite cannot exceed 30 days or 240 hours per waiver year;
3. Unused respite hours are not carried over into the next waiver year; and
4. Respite funding is available from one DHHS program source only.

Federal financial participation is not claimed for the cost of room and board.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified community based DD provider agency
Individual	Independent provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Certified community based DD provider agency
Provider Qualifications

License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.

When respite is provided in a community based residential setting such as a group home or extended family home, the CBDD provider may not claim for the cost of room and board.

DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service, nursing plan of care, or the individual's medical practitioner; and

Not be the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:

Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Independent provider
Provider Qualifications

License *(specify):*
Licensing is not a requirement to be a qualified individual respite provider.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual respite provider.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

Per NAC 404 Chapters 9 and 10:
A provider of this service must:

Be 18 years old or older. If no provider age 18 or older is available and acceptable to the family, and the child and family requests a younger provider, DHHS staff may authorize a provider no younger than age 18, considering the following:
The functioning level of the child;
The availability of back-up assistance; and
The capacity of the provider to meet the individual's needs in the case of an emergency; and
If s/he is less than 18 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian.
Not be a member of the individual's immediate household;
Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
Not be the usual non-paid caregiver or legally responsible relative;
Not be the guardian;
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service plan, nursing plan of care, or the individual's medical practitioner;
Have knowledge of basic first aid skills and of emergency responses;
Be authorized to work in the United States; and
Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of this waiver service.

All providers of waiver services who have direct contact with the individual receiving services must:
Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
Exhibit the capacity to: assume responsibility; follow emergency procedures; maintain schedules; and adapt to new situations.
Protect the confidentiality of the individual's and family's information;
Accept responsibility for the individual's safety and/or property;

Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
Continue to meet all applicable service-specific standards; and
Operate a drug-free workplace.

If Respite is provided outside of the family home, it is recommended that the family visit the facility or home in which the service is to be provided and agree to the provision of services in that location. The provider must ensure that:
The home/facility is architecturally designed to accommodate the needs of the individuals being served;
An operable phone and emergency phone numbers are available;
The home/facility is accessible to the individual, clean, in good repair, free from hazards, and free of rodents and insects;
The home/facility is equipped to provide comfortable temperature and ventilation conditions.
The toilet facilities are clean and in working order;
The eating areas and equipment are clean and in good repair;
The home/facility is free from fire hazards;
The furnace and water heater are located safely;
Firearms are in a locked unit;
Medications and poisons are inaccessible; and
Household pets have all necessary vaccinations.

Verification of Provider Qualifications

Entity Responsible for Verification:
Nebraska Department of Health and Human Services staff

Frequency of Verification:
annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Assistive Technology and Supports (ATS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Assistive Technology Supports (ATS) are specialized equipment and supplies that enable an individual to increase, maintain, or improve his/her functional capabilities. It includes the evaluation and purchasing (not leasing) of the assistive technology. It includes selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing the assistive technology device, and any training or technical assistance for the individual and unpaid caregivers.

ATS includes devices, controls, appliances, or other items that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment they live in, thus decreasing their need for assistance from others.

Approvable items are limited to those necessary to support individuals in their home or in the family's home, if living with his/her family, and must be appropriate to the needs of the individual as a result of limitations due to disability. An assessment will be completed to assist the individual to find an appropriate ATS solution. All devices and adaptations must be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design, and installation.
Items that are not covered include: items covered by Medicaid, recreational and/or exercise items, security items, devices or modifications already purchased or completed, computers (some exceptions may apply), furniture or appliances, air conditioners, clothing or bedding, or disposable medical or hygiene supplies.

Permanently attached devices, controls, and appliances may not be installed in residential settings that are owned or leased by providers of waiver services. If the individual resides in a rental unit, the individual or family/guardian must obtain written assurance from the landlord that the property will be made available to an individual with a disability for a period of at least three years after the funding of approved home modifications, by listing the property for rent on www.housing.ne.gov.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Total cost of ATS, home modifications, and vehicle modifications combined per participant per waiver year will not exceed $5,000.00. Unused funds do not carry over into the next waiver year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	independent provider
Agency	vocational rehabilitation agency
Agency	Independent living center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology and Supports (ATS)

Provider Category:

Individual

Provider Type:

independent provider

Provider Qualifications

License *(specify):*

All providers of ATS must meet applicable vendor licensure requirements and maintain current licensure according to local and state codes and statutes.
Neb. Rev. § 71-4603
Neb. Rev. § 81-2101 through 81-2141

Certificate *(specify):*

Certification is not required.

Other Standard *(specify):*

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

A provider of ATS must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license and certifications. Appropriately licensed/certified persons shall make or oversee all modifications.
A provider of ATS must continue to meet all applicable service-specific standards;
Not be a member of the individual's immediate household;
Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
Not be the usual non-paid caregiver or legally responsible relative;
Not be the guardian;
Operate a drug-free workplace;
Be authorized to work in the United States.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS staff

Frequency of Verification:

annually or per occurrence

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology and Supports (ATS)

Provider Category:

Agency

Provider Type:

vocational rehabilitation agency

Provider Qualifications

License *(specify):*

Licensure is not required.

Certificate *(specify):*

Certification is not required.

Other Standard *(specify):*

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

A provider of ATS must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

In addition, a provider of this service must not be the guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff verifies the qualifications of vocational rehabilitation agency. Vocational Rehabilitation verifies the subcontracted provider.

Frequency of Verification:
annually or per occurrence

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology and Supports (ATS)

Provider Category:
Agency

Provider Type:
Independent living center

Provider Qualifications

License *(specify):*
Licensure is not required.

Certificate *(specify):*
No certification is required.

Other Standard *(specify):*
A provider of ATS must ensure that all items and equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

In addition, a provider of this service must not be the guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff verifies the qualifications of independent living center. Independent living center verifies the subcontracted provider.

Frequency of Verification:
annually or per occurrence

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Community Living and Day Supports (CLDS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Community Living and Day Supports (CLDS) provides the necessary assistance and supports to meet the daily needs and preferences of the individual. CLDS is provided with the individual present to ensure adequate functioning in the individual's home, as well as assisting the individual to participate in a wide range of activities outside the individual's or provider's home. CLDS may also provide the necessary assistance and supports to meet the employment and/or day service needs of the individual in integrated, community settings.

The Community Living and Day Supports service includes the following components:
Individual assistance with hygiene, bathing, eating, dressing, grooming, toileting, transferring, or basic first aid with the intent of preparing for and participating in activities outside of the individual's or provider's home.
Supervision and monitoring during the individual's awake hours for the purpose of ensuring the individual's health and safety. CLDS cannot be delivered overnight when the individual is sleeping.
Supports to enable the individual to access the community. This may include someone hired to accompany and support the individual in all types of community settings. CLDS is generally not delivered in the provider's home.
Supports to assist the individual to develop self-advocacy skills, exercise rights as a citizen, and acquire skills needed to exercise control and responsibility over other support services, including managing generic community resources and informal supports.
Supports to assist the individual in identifying and sustaining a personal support network of family, friends, and associates.

Household activities necessary to maintain a home living environment on a day-to-day basis, such as meal preparation, shopping, cleaning, and laundry, limited to 20 percent or less of the total authorized weekly hours.

Home maintenance activities needed to maintain the home in a clean, sanitary, and safe environment, limited to 20 percent or less of the total authorized weekly hours.
Supports to enable the individual to maintain or obtain employment. This may include someone hired to accompany and support the individual in an integrated work setting. Integrated settings are those considered as available to all members of the community. The employment supports are delivered informally. That is, the provider is not required to write formal training programs with long term goals, short term objectives, strategies, and data collection methodology. The supports delivered under CLDS are considered "natural teaching moments".

Supports to enable the individual to access services and opportunities available in community settings. This may include accompanying the participant to and facilitating participation in general community activities, community

volunteer work, and services provided in community settings such as senior centers and adult day centers. CLDS must not be duplicative or replace other supports available to the individual. The services provided under CLDS are different from those provided under Targeted Case Management (DD service coordination) in that the CLDS provider supports the individual by providing transportation if necessary and remaining with the individual during receipt of the services and community activities. Nebraska service coordinators do not provide direct services and supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

CLDS cannot be provided by the usual caregiver. The term "usual caregiver" means a person(s) who resides with the individual, is not paid to provide services, and is responsible for the care and supervision of the child on a 24-hour basis. Payment for CLDS does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). CLDS cannot be provided by the legal guardian.

Assistance with personal care needs or household activities is available only to those individuals who live with an unpaid caregiver. Assistance is limited to activities necessary to support individuals in their home and must be appropriate to the needs of the individual as a result of limitations due to disability.

CLDS is not intended to duplicate or replace other supports available to the individual, including natural supports and state or federally funded services.

Household activities and home maintenance activities are for the purpose of fulfilling duties the individual would be expected to do to contribute to the operation of the household, if it were not for the individual's disability and are limited to 20 percent or less of the total authorized weekly hours.

Homemaker services cannot be authorized when an individual receives Community Living and Day Supports.

Routine health care supports may be furnished to the extent permitted under Nebraska state law.

Individual assistance with money management and personal finances may be provided, but the provider cannot act as the representative payee.

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement and as required by law, will be examined prior to any authorization of home maintenance services under CLDS.

The individual must supply necessary cleaning products and equipment when a provider cleans or cares for household equipment, appliances, or furnishings in the individual's home.

The individual must supply necessary cleaning products and equipment or money for a Laundromat when a provider cleans or cares for the individual's clothing.

Payment for the work performed by the individual is the responsibility of the employer of that individual. Covered services do not include those provided in specialized developmental disability provider settings, workstations, or supported employment settings.

Supports provided under CLDS must be those that are above and beyond the usual services provided in such a setting and not duplicate services expected to be the responsibility of immediate household members, a senior center, adult day center, or employer.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. CLDS cannot be delivered at the same time as the delivery of Companion Home Residential service, In-Home Residential service, Workstation service, Day Habilitation service, Vocational Planning service, Supported Integrated Employment, Integrated Community Employment, Respite, or Retirement services.

Waiver services will not be furnished to an individual while s/he is an inpatient of a hospital, nursing facility, or ICF/IDD. Room and board is not included as a cost that is reimbursed under this waiver.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	independent provider
Agency	community provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living and Day Supports (CLDS)

Provider Category:
Individual
Provider Type:
independent provider
Provider Qualifications

License *(specify):*
Licensing is not a requirement to be a qualified individual CLDS provider.
Certificate *(specify):*
Certification is not a requirement to be a qualified individual CLDS provider.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

Per NAC 404 Chapters 9 and 10:
A provider of this service must:

Be 18 years old or older. If no provider age 18 or older is available and acceptable to the family, and the child and family requests a younger provider, DHHS staff may authorize a provider no younger than age 18, considering the following:
The functioning level of the child;
The availability of back-up assistance; and
The capacity of the provider to meet the individual's needs in the case of an emergency; and
If s/he is less than 18 years old and not emancipated, have the service provider agreement signed by his/her parent or legal guardian.
Not be a member of the individual's immediate household;
Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
Not be the usual non-paid caregiver or legally responsible relative;
Not be the guardian;
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service plan, nursing plan of care, or the individual's medical practitioner;
Have knowledge of basic first aid skills and of emergency responses;
Be authorized to work in the United States; and
Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of this waiver service.

All providers of waiver services who have direct contact with the individual receiving services must:
Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;
Obtain adequate information on the supports necessary to meet the medical and personal needs of the

individual;
Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
Exhibit the capacity to: assume responsibility; follow emergency procedures; maintain schedules; and adapt to new situations.
Protect the confidentiality of the individual's and family's information;
Accept responsibility for the individual's safety and/or property;
Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
Continue to meet all applicable service-specific standards; and
Operate a drug-free workplace.

In addition, a provider of this service must not be the guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Health and Human Services staff
Frequency of Verification:
annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Living and Day Supports (CLDS)

Provider Category:
Agency
Provider Type:
community provider agency
Provider Qualifications

License *(specify):*
Licensure is not a requirement to be a qualified CLDS provider.
Certificate *(specify):*
Certification is not a requirement to be a qualified CLDS provider.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

Per NAC 404 Chapters 9 and 10:
A provider of this service must:

Be 18 years old or older.
Not be a member of the individual's immediate household;
Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
Not be the usual non-paid caregiver or legally responsible relative;
Not be the guardian;
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service plan, nursing plan of care, or the individual's medical practitioner;
Have knowledge of basic first aid skills and of emergency responses;
Be authorized to work in the United States; and
Possess a valid driver's license and insurance as required by Nebraska law, if transportation is provided as a component of this waiver service.

Provide services in a manner demonstrating acceptance of, respect for, and a positive attitude toward people who are disabled;
Have training or experience in the performance of the service(s) being provided and be able to perform the tasks required for the individual's needs;

Obtain adequate information on the supports necessary to meet the medical and personal needs of the individual;
Observe and report all changes which affect the individual and/or the individual's plan to the service coordinator, taking action as necessary;
Have knowledge and understanding of the needs of individuals with intellectual or developmental disabilities;
Exhibit the capacity to: assume responsibility; follow emergency procedures; maintain schedules; and adapt to new situations.
Protect the confidentiality of the individual's and family's information;
Accept responsibility for the individual's safety and/or property;
Exercise universal precautions in the delivery of services, have the physical capability to provide the service, and provide a physician's verification statement, if requested;
Continue to meet all applicable service-specific standards; and
Operate a drug-free workplace.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS

Frequency of Verification:
annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Home Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Home Modifications are those physical adaptations, or structural changes to the individual's home that are necessary to ensure the health, welfare, and safety of the individual, and/or which enable the individual to function with greater independence in the home.

Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Approvable modifications are limited to those necessary to maintain the individual in their own participant-directed home (not provider operated or controlled) or in the family's home, if living with his/her family.

Approvable modifications do not include adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual. Examples of home modifications that are not approvable include:
• Home maintenance and repair such as carpeting or roof repair;
• Access to the basement for use as a storm shelter or recreation;
• Recreational pools and decks;
• Remodeling not related to accessibility or disability-related needs;
• New construction (exception may be made in cases where the existing bathroom cannot be modified for accessibility);
• Restrictive modifications that replace supervision, such as half-doors, fences, and security items. Items that assist in supervision and are specifically related to the individual's needs due to disability may be considered, if necessary to ensure safety; and
• Central air conditioning.

DDD will not approve home modifications if the adaptations are available under the Medicaid State Plan or from a third party source.

The home must not present a health and safety risk to the individual other than that corrected by the approved home modifications.

If the individual resides in a rental unit, the individual or family/guardian must obtain written assurance from the landlord that the property will be made available to an individual with a disability for a period of at least three years after the funding of approved home modifications, by listing the property for rent on www.housing.ne.gov.

Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Home modifications are available only to individuals residing in the family's home, if living with his/her family, or their own participant directed (not provider operated or controlled) home.

Total cost of ATS, home modifications, and vehicle modifications combined per participant per waiver year will not exceed $5,000.00. Unused funds do not carry over into the next waiver year.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	vocational rehabilitation agency
Agency	Independent Living Center
Individual	independent provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:
Agency
Provider Type:
vocational rehabilitation agency
Provider Qualifications

License *(specify):*
Qualified providers must meet applicable State licensure requirements as described in title 391 NAC.

All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license and certifications. Home modification must be provided in accordance with applicable local and state building codes. Appropriately licensed/certified persons shall make or oversee all modifications.

Certificate *(specify):*
Certification is not required.

Other Standard *(specify):*
A provider of home modifications must ensure that all items and equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.

Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;

Ensure all products and materials installed shall conform to specifications. No “blemished,” “seconds,” or reused building materials shall be used unless otherwise noted in the quote and approved before installation;

Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;

Warrant all work, new materials, and new products for a minimum of one year;

Ensure any and all subcontractor’s work will conform to the terms and conditions of this contract and accept sole responsibility; and

Be authorized to work in the United States.

In addition, a provider of this service must not be the guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff verifies the qualifications of vocational rehabilitation agency staff. Vocational Rehabilitation agency staff verifies the subcontracted provider.

Frequency of Verification:
per occurrence

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:
Agency

Provider Type:
Independent Living Center

Provider Qualifications

License *(specify):*
Qualified providers must meet applicable State licensure requirements as described in title 391 NAC.

All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license and certifications. Home modification must be provided in accordance with applicable local and state building codes. Appropriately licensed/certified persons shall make or oversee all modifications.

Certificate *(specify):*
Certification is not required.

Other Standard *(specify):*
A provider of home modifications must ensure that all items and equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.

Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;

Ensure all products and materials installed shall conform to specifications. No “blemished,” “seconds,” or reused building materials shall be used unless otherwise noted in the quote and approved before installation;

Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;

Warrant all work, new materials, and new products for a minimum of one year;

Ensure any and all subcontractor’s work will conform to the terms and conditions of this contract and accept sole responsibility; and

Be authorized to work in the United States.

In addition, a provider of this service must not be the guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS staff verifies the qualifications of independent living center agency. Independent Living Center verifies the subcontracted provider.
Frequency of Verification:
annually or per occurrence

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:
Individual
Provider Type:
independent provider
Provider Qualifications
License *(specify):*
All general contractors shall meet all applicable federal, state, and local laws and regulations, including maintaining appropriate license and certifications. Home modification must be provided in accordance with applicable local and state building codes. Appropriately licensed/certified persons shall make or oversee all modifications.

All individual providers of home modifications performing electrical or plumbing work must meet applicable local and state licensure requirements and maintain current licensure.
Neb. Rev. § 71-4603
Neb. Rev. § 81-2101 through 81-2141
Certificate *(specify):*
Certification is not a requirement.
Other Standard *(specify):*
A provider of home modifications must ensure that all items and equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.

A provider of home modifications must continue to meet all applicable service-specific standards;
Provide all services in accordance with applicable local and state building codes, OSHA regulations, and Nebraska Department of Labor regulations;
Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices;

Ensure all products and materials installed shall conform to specifications. No “blemished,” “seconds,” or reused building materials shall be used unless otherwise noted in the quote and approved before installation;

Accept responsibility for repair of all surfaces including furniture, walls, floor covering, doors, woodwork and trim, exterior pavement and yards, equipment, and fixtures affected during the course of construction, to original or better condition;

Warrant all work, new materials, and new products for a minimum of one year;

Ensure any and all subcontractor’s work will conform to the terms and conditions of this contract and accept sole responsibility;

Be authorized to work in the United States;

Not be a member of the individual’s immediate household;

Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
Not be the usual non-paid caregiver or legally responsible relative;
Not be the guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff

Frequency of Verification:
annually or per occurrence

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
PERS is an electronic device which enables individuals to secure help in an emergency. The individual may also wear a portable PERS button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once a PERS button is activated.

A provider of PERS must:
1. Instruct the individual about how to use the PERS device;
2. Obtain the individual's or authorized representative's signature verifying receipt of the PERS unit;

3. Ensure that response to device signals (where appropriate to the device) will be provided 24 hours per day, seven days per week;
4. Furnish a replacement PERS unit to the individual within 24 hours of notification of malfunction of the original unit while it is being repaired;
5. Update list of responder and contact names at a minimum semi-annually to ensure accurate and correct information;
6. Ensure monthly testing of the PERS unit; and
7. Furnish ongoing assistance when needed to evaluate and adjust the PERS device or to instruct the individual in the use of PERS devices, as well as to provide for system performance checks.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
PERS services are limited to those individuals who live alone or who are alone for significant parts of the day and have no regular unpaid caregiver or provider for extended periods of time, and who would otherwise require extensive routine supervision.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:
Agency
Provider Type:
Independent
Provider Qualifications

License *(specify):*
No license is required to be a PERS provider.
Certificate *(specify):*
Certification is not required.
Other Standard *(specify):*
All providers of waiver services must be Medicaid providers as described in 471 NAC 2-000.

A provider of PERS must ensure that all items and assistive equipment provided meet the applicable standards of manufacture, design, and installation. NAC 404 9-000

Verification of Provider Qualifications

Entity Responsible for Verification:
Nebraska Dept. of Health and Human Services staff
Frequency of Verification:
annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Retirement Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Retirement service is available to individuals who are of the typical retirement age. Participants of this service have chosen to end employment or participation in day services or are no longer able to be employed or participate in day services due to physical disabilities or stamina. Retirement service is structured supports consisting of day activities or residential support. Retirement service is provided in a home setting or community day activity setting and may be provided as a day service, a residential service, or both. Retirement service may be self-directed or provider controlled. The outcome of retirement service is to treat each person with dignity and respect, and to the maximum extent possible maintain skills and abilities, and to keep the person engaged in their environment and community through optimal care and support to facilitate aging within the person's home and community. Individuals may choose, when appropriate, to receive retirement residential service in place of a residential habilitative service. Individuals may choose, when appropriate, to receive retirement day service in place of a day habilitative service or integrated employment, or individuals may choose, when appropriate, to receive only retirement service in place of a residential habilitative service, AND in place of a day habilitative service or integrated employment.

Retirement service is supports designed to actively stimulate, encourage and enable active participation; develop, maintain, and increase awareness of time, place, weather, persons, and things in the environment; introduce new leisure pursuits, establish new relationships; improve or maintain flexibility, mobility, and strength; develop and maintain the senses; and to maintain and build on previously learned skills.

Active supports must be furnished in a way which fosters the independence of each individual. Strategies for the delivery of active supports must be person centered and person directed to the maximum extent possible and must be identified in the service plan.

Retirement service may include personal care, protective oversight, and supervision as applicable to the individual when provider staff is present. Individuals may need supports to assist them in meaningful retirement activities in their communities. This might involve altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/ or other senior related activities in their communities. Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. Meals provided as part of retirement service does not constitute a "full nutritional regimen" (3 meals per day).

Retirement day service may be provided as a continuous or intermittent service. Continuous retirement day service is provided for seven or more hours per day, generally, between the hours of 7:00 am and 5:00 pm, Monday – Friday and delivered in a non-institutional, community setting that may include people without disabilities. DD provider-operated retirement day settings must be made available to people without disabilities.

Daily rates are available for continuous retirement day service when the person receives this service for four or more hours. Hourly rates are also available for times when the individual might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75). Individuals that choose retirement day service cannot receive Day Habilitation, Vocational Planning service, Supported Integrated Employment, or Integrated Community Employment.

Retirement residential service is generally delivered in the evenings and on the weekends to individuals who no longer participate in a residential habilitative service due to physical disabilities or stamina. Retirement residential service may be provided as a continuous or intermittent service, and are generally delivered outside of the hours of 7:00 a.m. to 5:00 p.m. Monday - Friday. Continuous retirement residential service is provided for seven or more hours per day and may be provided in the individual’s own participant-directed home, in the family home, if the individual lives with their family, or provider operated residences. The home or residence must be in an integrated community setting. Individuals that choose retirement residential service cannot receive In-home residential service, Companion Home residential service, Extended Family Home residential service, or Group Home residential service.

Individuals that choose retirement service may also choose Community Living and Day Supports (CLDS), but these services may not be billed during the same period of the day. When retirement service is not delivered continuously/consecutively for four or more hours, the retirement service must be billed at an hourly rate. CLDS can only be billed at an hourly rate on days when no daily rate is billed for Retirement service. When Retirement and CLDS are provided as a day service during one typical workday, the delivered services are billed in hours. When Retirement and CLDS are provided as a residential service during one calendar day, the delivered service is billed in hours.

When retirement service is delivered in a provider operated residence, there must be staff on-site or within proximity to allow immediate on-site availability at all times to the individual receiving services. Staff must be available to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, to provide supervision, safety, and security, and to provide active supports to keep the person actively engaged in their environment.

The personal living space and belongings of others must not be utilized by others receiving retirement services. When retirement service is delivered in residences, only shared living spaces such as the living room, kitchen, bathroom, and recreational areas may be utilized, and when retirement service is delivered to two or more individuals, different residences must be utilized on a rotating basis.

Transportation between the participant's place of residence and other waiver service sites and places in the community is provided as a component of retirement service. Transportation may be provided between the individual's place of residence and the day service site or between day service sites (in cases where the individual receives habilitative (teaching and supporting) services in more than one place). Transportation into the community to shop, attend recreational and civic events, go to the senior center, adult day care center, or other

community activities is a component of retirement services and is included in the rate to providers. The time when an individual is transported by a provider may be billed. The individual must be with the provider staff in order for transportation time to be claimed. Transportation for the provider staff to and from the individual's home is not included as a component of this service and cannot be claimed. Transportation by the provider shall not replace transportation that is already reimbursable under the Medicaid non-emergency medical transportation program. The service planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation by the provider is not intended to replace generic transportation or to be used merely for convenience.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payments for retirement service is not made for room and board, the cost of facility maintenance, upkeep, and improvement.

Payment for retirement service does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted). Payments will not be made for the routine care and supervision which would be expected to be provided by a family, group home provider, or extended family home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified community based DD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Retirement Services

Provider Category:

Agency

Provider Type:

Certified community based DD provider agency

Provider Qualifications

License *(specify):*

No license is required.

Certificate *(specify):*

DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.

DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service, nursing plan of care, or the individual's medical practitioner; and

Not be the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Supported Integrated Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supported Integrated Employment (SIE) is the ongoing supports to individuals who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage, or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Integrated Employment focuses on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum inclusion and personal accomplishment in the working community. Habilitative training, (teaching and supporting) may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives. SIE is furnished as specified in the service plan and delivered intermittently. Intermittent services imply that staff support is provided when the services and supports are needed.

SIE also includes the provision of personal care and protective oversight and supervision when applicable to the individual. The teaching, activities, services, supports, and strategies are documented in the service plan and delivered based on the service plan. Individuals receiving SIE must have employment-related goals in their person-centered service plan; the general habilitative activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the successful outcome of SIE.

SIE takes place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such as within a business or a community setting not owned or controlled by a DD provider, where individuals without disabilities work or meet together. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Staff are present at all times the individual is present. Discreet training activities and supports during typical working hours is allowed in preparation for leaving the place where the person lives. Habilitative training and teaching provided may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives, with the focus on attaining the outcome of integrated community employment.

Prior to learning to access transportation independently, transportation may be provided between the individual's place of residence and the Supported Integrated Employment services or between habilitation (teaching and supporting) service sites (in cases where the individual receives habilitation services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitation (teaching and supporting) services. The cost of transportation between Supported Integrated Employment and Day Habilitation, Vocational Planning service, and Workstation service should be billed under those waiver services and not this service.

Supported Integrated Employment can only be billed in half, quarter, or full hour increments. An hour of service equates to one clock hour. SIE may take place in conjunction with Workstation service, Vocational Planning service, Day Habilitation service, or other day activities but may not be billed at the same time during a given day. An individual receiving Supported Integrated Employment cannot receive Integrated Community Employment.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan. This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan

services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Payment for this waiver service does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified community based DD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Integrated Employment

Provider Category:
Agency
Provider Type:
Certified community based DD provider agency
Provider Qualifications

License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.

DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual’s dietary needs, as documented in the service, nursing plan of care, or the individual’s medical practitioner; and

Not be the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).

Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Team Behavioral Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Team behavioral consultation (TBC) is consultation by highly specialized teams with behavioral and psychological expertise when individuals with DD experience psychological, behavioral, or emotional instability which has been resistant to other standard habilitative interventions and strategies that have been attempted by the individual's service plan team. This service is not facility-based or site-specific and on-site observation of the individual occurs where the individual lives, works, or receives day services. Sometimes in rural areas of the state, community resources, such as psychologists or psychiatrists are not readily available to consult with or participate in meetings, or have very little experience with treating individuals with DD. TBC service may be requested by the service plan team or directed by DDD central office and the need for the service is reflected in the

service plan.

The TBC service is provided under the direction of a Licensed Clinical Psychologist, and include medical staff and other professionals as needed. TBC service includes reviewing referral information, an entrance conference, on-site observations, interviews, assessments, training to direct support staff or unpaid caregivers, identification of the need for referral(s) to other services if applicable, an exit conference, report of findings and recommendations, and follow-up. Specialized applied behavioral and analytic consultation regarding habilitation needs and less intense maladaptive behaviors is available.

TBC service includes assessments on the individual's comprehensive needs and circumstances, clinical case consultation, follow-up support, and booster training sessions focused on specific problems of an individual utilizing positive behavioral supports and applied behavior analysis technique.

The service begins with submission of a referral to DDD central office to log and forward to the assigned TBC team. The TBC team contacts the individual's service coordinator (SC) to schedule a consultation visit and the SC submits informational packet to the TBC team for review prior to the scheduled visit.

TBC service includes an initial meeting with the individual, legal representative and/or parent, service coordinator, habilitation services staff and other professionals serving the person in the community and obtain the history of the individuals past treatment, if any. This meeting is designed to further explore the unacceptable behavior(s) and plan the schedule for the on-site consultation.

A comprehensive evaluation in the format approved by DDD is conducted and includes addressing the individual's developmental disabilities, risk analysis if applicable, treatment, habilitative teaching and training, staffing requirements, and observations and assessments where the individual lives and receives services depending upon when and where the specific problem behaviors are exhibited, noting current interventions and efficacy. Observations where the individual lives and/or takes part in day services or other activities are conducted at any time of the day or night, depending upon when and where the specific negative behaviors are exhibited. Service plan team members are interviewed, and assessments are completed.

Habilitative training and teaching, and if necessary, behavioral interventions are determined and developed, implemented, evaluated, and revised, with the outcome being utilization of an appropriate habilitative program. The TBC provider will conduct adherence and fidelity checks regarding the implementation of changes to the service plan based on team acceptance of recommendations from Team Behavioral Consultation. These services may not overlap or duplicate services under the Medicaid State Plan. Medicaid services must be billed to the Medicaid and Long Term Care Division and are not covered under TBC service.

Training is delivered to the providers and unpaid caregivers as applicable and requested, such as best practices in applied behavioral techniques, positive behavioral support, medical and psychological conditions, or environmental impact to service delivery.

Findings and recommendations are written and discussed with the team at the exit conference and a copy is provided to DDD central office. The individual is present for the consultation. The recommendations from the TBC service provider for addressing behaviors and intervention strategies must be addressed by the individual's service plan team and changes resulting from the recommendations are documented in the service plan.

If at any time the TBC team identifies a need for a referral as a result of the review of the individual case file, observations, interviews, and/or completion of assessments, the TBC team will notify the individual's DDD service coordinator to recommend/direct that a referral be made to address identified needs such as, but not limited to a medication review, dental work, medical evaluation(s), or a physical nutritional evaluation. Such referral recommendations are documented in the TBC report.
The recommendations from the TBC provider for addressing behaviors and intervention strategies must be addressed by the individual's team and changes resulting from the recommendations are documented in the service plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Team behavioral consultation is only available to individuals receiving DD service coordination and HCBS waiver services.

Payment for TBC does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

TBC will not be available to individuals that receive behavioral risk services or retirement services.

TBC will not be furnished to an individual while s/he is an inpatient of a hospital, nursing facility, or ICF-IDD. Room and board is not included as a cost that is reimbursed under this service.

To avoid overlap or duplication of service, TBC is limited to those services not already covered under the Medicaid State Plan or which can be procured from other formal or informal resources such as IDEA or Rehab act of 1973. Furthermore, TBC will not duplicate other services provided through this waiver.

The authorized amount of TBC is not determined using the objective assessment process. The rates for TBC is set by DDD. TBC service rate is a cost adjustment model and includes rates for an occurrence and by the hour. The rates take into consideration the staff salaries, benefits, and preparation time to review information and schedule the site visit; travel time which varies from 2 to 9 hours one way; on-site time, which includes a preliminary meeting, observing the individual during all awake hours in all settings; and follow-up time, which includes providing report of consultation, conference calls or meetings as necessary, and post recommendation surveys. The rate of this service is adjusted annually, based on the previous year's cost of delivering team behavioral consultation.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	approved home and community based waiver provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Team Behavioral Consultation

Provider Category:
Agency

Provider Type:
approved home and community based waiver provider

Provider Qualifications

License *(specify):*
TBC Staff or agencies that provide a service for which a license, certification, or registration, or other credential is required, must hold the license, certification, registration, or credential in accordance with applicable state laws and regulations.
Neb. Rev. § 38-2121 through 38-2123
Neb. Rev. § 38-3115 through 38-3120
172 NAC 94-000

Certificate *(specify):*
Certification by DDD is not required.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

The agency or representative of the agency delivering direct services and supports must:
Be age 18 or older;
Not be a legally responsible relative or guardian of the participant;
Not be the parent, spouse, or child (biological, step, or adopted) of the participant.
Be authorized to work in the United States;
Have experience offering team behavioral consultation;
Not provide TBC in cases where the provider or subcontracted provider is also the habilitation provider; and
Have on staff or under contract a psychologist, medical staff, mental health practitioner, behavioral specialist, and other professionals as needed.
Not be the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).

Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Vehicle modifications to vehicles may be made for purposes of accommodating the special needs or the participant when the vehicle is privately owned by the individual or his/her family and is used to meet the participant's transportation needs.

The vehicle must be in good operating condition and modifications must be made in accordance with applicable standards of manufacturing, design, and installation. The following are excluded specifically from the participant's primary means of transportation:
1) Adaptations or improvements to the vehicle that are of a general utility, & are not a medical or remedial benefit to the individual;
2) Purchase or lease of a vehicle; and
3) Regularly scheduled upkeep & maintenance of a vehicle except upkeep & maintenance of the modifications.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Total cost of ATS, home modifications, and vehicle modifications combined per participant per waiver year will not exceed $5,000.00. Unused funds do not carry over into the next waiver year.

Payment for this waiver service does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent provider
Agency	Independent Living Center
Agency	Vocational Rehabilitation agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Individual
Provider Type:
Independent provider
Provider Qualifications
License *(specify):*
Licensure is not a requirement.
Certificate *(specify):*
Certification is not required.
Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title NAC 471 2-000.

Provide all services in accordance with applicable local and state codes, OSHA regulations, and Nebraska Department of Labor regulations;

Ensure all modifications will be made or overseen by appropriately licensed and/or certified persons, OR persons skilled in the respective trades in a manner consistent with the standards of the respective trades, governing codes, and generally accepted construction practices.

A provider of vehicle modification services must:
Ensure that the vehicle is in good operating condition;
Perform modifications in accordance with applicable standards of manufacturing, design, and installation;
Warrant all work, new materials, and new products for a minimum of one year;
Ensure any and all subcontractor's work will conform to the terms and conditions of this contract and accept sole responsibility;
Be authorized to work in the United States;
Not be a member of the individual's immediate household;
Not be the parent, spouse, or child (biological, step, or adopted) of the participant;
Not be the usual non-paid caregiver or legally responsible relative;
Not be the guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
NDHHS staff

Frequency of Verification:
per occurrence

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency

Provider Type:
Independent Living Center

Provider Qualifications

License *(specify):*
Licensure is not a requirement.

Certificate *(specify):*
Certification is not required.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff verifies the qualifications of independent living center. Independent living center verifies the subcontracted provider.

Frequency of Verification:
per occurrence

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency

Provider Type:

Vocational Rehabilitation agency

Provider Qualifications

License *(specify):*
Licensure is not a requirement.

Certificate *(specify):*
Certification is not a requirement.

Other Standard *(specify):*
All providers of waiver services must be a Medicaid provider as specified in the applicable Nebraska Administrative Code title 471 NAC 2-000.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS staff verifies the qualifications of vocational rehabilitation agency. Vocational Rehabilitation verifies the subcontracted provider.

Frequency of Verification:
per occurrence

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Vocational Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Vocational Planning service is a prevocational service with focus on enabling the individual to attain work experience through career planning, job searching, and short-term paid and unpaid work experience with the goal or outcome of Vocational Planning service being integrated competitive employment. A person receiving Vocational Planning service may pursue employment opportunities at any time to enter the general work force. Vocational Planning service is furnished as specified in the service plan and is delivered intermittently. Intermittent services imply that staff support is provided when the services and supports are needed.

This prevocational service includes activities that are not primarily directed at teaching skills to perform a particular job, but at underlying habilitative goals (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that are associated with building skills necessary to perform compensated work in community integrated employment. Vocational Planning service, regardless of setting, is delivered for the purpose of furthering habilitation goals that will lead to greater opportunities for competitive and integrated employment and career advancement at or above minimum wage. Vocational Planning service is not a vocational service, which is not covered through waivers.

Vocational Planning service includes formalized training and staff supports which take place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such as within a business or a community setting not owned or controlled by a DD provider, where individuals without disabilities work or meet together. Discreet teaching and supporting during typical working hours is allowed in preparation for leaving the place where the person lives. Direct training or teaching and supports will be designed to provide the individual with face to face instruction necessary to learn work-related responsibilities, work skills, and appropriate work behavior.

Vocational Planning service focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum inclusion and personal accomplishment in the working community. Vocational Planning service may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives. Vocational Planning service also includes the provision of personal care and protective oversight and supervision when applicable to the individual. The teaching, activities, services, supports, and strategies are documented in the service plan and delivered based on the service plan. Individuals receiving Vocational Planning service must have employment-related goals in their person-centered service plan; the general habilitative activities must be designed to support such employment goals. Competitive, integrated employment in the community is considered to be the successful outcome of Vocational Planning service.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Vocational Planning service may include career planning that is person-centered and team supported to address the individual's particular needs to prepare for, obtain, maintain or advance employment. Career planning is not a required component of Vocational Planning service and is not a prerequisite for Supported Integrated Employment or Integrated Community Employment. Career planning includes training, or teaching and supporting, for development of self-awareness, as well as assessment of skills, abilities, and needs for self-identifying career goals and direction, including resume or business plan development for customized home businesses. Assessment of skills, abilities, and needs is a person-centered team responsibility that engages all team members to support an individual in identifying a career direction and developing a plan for achieving competitive integrated community employment at or above the state's minimum wage, but not less than the customary wage and level of benefits paid by the employer of the same or similar work performed by individuals without disabilities. The documented outcome of the career planning component is the stated career goals and career direction and strategies for the acquisition of skills and abilities needed for work experience in preparation for supported community employment or integrated community employment. Establishment of career goals may not take place at the same time as other Vocational Planning activities.

Vocational Planning service with focus on career planning and strategies for implementing career goals may involve assisting the individual in accessing an Employment Network, the Nebraska Work Incentive Network (WIN), Ticket to Work services, Work Incentive Planning and Assistance (WIPA) services, or other qualified service programs that provide benefits planning.

Vocational Planning service may include job searching designed to assist the individual, or on behalf of the

individual, to locate a job or development of a work experience on behalf of the individual. Job searching may take place in the individual's residence, in integrated community settings, or in provider staff office areas. Job searching may not take place in a fixed-site facility in the areas where other individuals are receiving continuous day habilitative services. Job searching with the individual will be provided on a one to one basis to achieve the outcome of this service.

Vocational Planning service may include work experiences that are paid or unpaid, such as volunteering, apprenticing, interning, job shadowing, etc. A work experience takes place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, with the focus on attaining the outcome of integrated community employment. Training, or teaching and supporting, provided during a work experience may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

Prior to learning to access transportation independently, transportation may be provided between the individual's place of residence and the vocational planning service or between day service sites (in cases where the individual receives habilitative (teaching and supporting) services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of habilitative services. The cost of transportation between vocational planning service and day habilitation service, workstation service, and integrated community employment should be billed under those waiver services and not this service.

Vocational Planning service can only be billed in half, quarter, or full hour increments. An hour of service equates to one clock hour. Vocational Planning service may take place in conjunction with Supported Integrated Employment, Integrated Community Employment service, Workstation service, Day Habilitation service, or other day activities but may not be billed at the same time during a given day.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan. This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Some components of Vocational Planning service are time-limited. Establishment of career goals through career planning may not exceed three months. If the outcome of career planning is not reached within three months, a team meeting must be held to change the service plan. Unpaid work experiences must lead to paid employment and are therefore time-limited. Work experiences for which the general population is paid to perform may not last beyond six months. Volunteering to provide services and supports in an integrated community setting for which the general population does not get paid to perform are not considered to be a work experience and are not time-limited. No more than three individuals may participate in the same paid or unpaid work experience at the same time.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified community based DD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vocational Planning

Provider Category:
Agency
Provider Type:
Certified community based DD provider agency
Provider Qualifications
License *(specify):*
No license is required.
Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.

DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service, nursing plan of care, or the individual's medical practitioner; and

Not be the legal guardian.
Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Workstation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

04 Day Services | 04020 day habilitation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Workstation service is a habilitative service with formalized training and staff supports for the acquisition, retention, or improvement in self-help, behavioral, and adaptive skills that enhance social development and develop skills in performing activities of daily living, community living, and employment. Workstation service take place during typical working hours, in a non-residential setting, separate from the individual's private residence or other residential living arrangement, such as within a business or a community setting where individuals without disabilities work or meet together. Discreet training activities and supports during typical working hours is allowed in preparation for leaving the place where the person lives.

Workstation service focus on the acquisition of work skills, appropriate work behavior, and the behavioral and adaptive skills necessary to enable the individual to attain or maintain his or her maximum inclusion, and personal accomplishment in the working community. Training activities may include teaching such concepts as compliance, attendance, task completion, problem solving, and safety as well as accessing transportation independently and explicit employment objectives.

This service also includes the provision of personal care, health maintenance activities, and protective oversight when applicable to the individual, as well as supervision. In addition, the intensity of supervision will also be outlined in the service plan. Health maintenance activities, such as medication administration and treatments that are routine, stable, and predictable may be provided by medication aides and other unlicensed direct support professionals and require nurse or medical practitioner oversight of delegated activities to the extent permitted under applicable State laws. Health maintenance activities, supervision, and assistance with personal needs are provided when identified as a need and documented in the service plan. The habilitative services, supports, and strategies are documented in the service plan and delivered based on the service plan.

Workstation service is delivered continuously and provides paid work experiences in preparation for competitive employment. Generally, this service is provided between the hours of 7:00 am and 5:00 pm, or can be delivered in an alternate schedule, as documented in an individual's service plan. Workstation service is a continuous day service and staff support is continuous, that is, staff are present at all times the individual is present. Continuous day services are expected to be available for no less than seven hours per day. Daily rates are available for workstation service when the person receives this service for four or more consecutive hours. Hourly rates are also available for times when the individual might be in this service a portion of the day but not a full four hours. An hour of service equates to one clock hour. Services may be billed in half and quarter hours (.25, .50, and .75). When this service is not delivered continuously/consecutively for four or more hours, it must be billed at an hourly rate.

This service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the

Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Transportation may be provided between the individual's place of residence and the workstation service or between other service sites (in cases where the individual receives day services in more than one place). The cost of transportation is included in the rate paid to providers of the appropriate type of waiver services. The cost of transportation between workstation and other habilitative waiver service sites should be billed under those waiver services and not this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount of authorized services is the individual's approved annual budget and is provided based on the individual's preferences to the extent possible, and as documented in the service plan.

Payment for this waiver service does not include payments made, directly or indirectly to members of the individual's immediate family, defined as parent (biological, step, or adoptive), spouse, or child (biological, step, or adopted).

This service will not overlap with, supplant, or duplicate other services provided through the waiver or Medicaid State plan services. Each waiver service must be prior-authorized to avoid duplicative billing with other waiver services.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	certified community-based DD provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Workstation

Provider Category:
Agency
Provider Type:
certified community-based DD provider agency
Provider Qualifications

License *(specify):*
No license is required.

Certificate *(specify):*
DD Provider agencies must be certified by the Division of Developmental Disabilities in accordance with applicable state laws and regulations.

A qualified DD provider agency must meet standards, as described in the following state statutes and regulations in Nebraska Administrative Code (NAC).

404 NAC Community Based Services For Individuals with Developmental Disabilities - 4-000 Core Requirements For Specialized Providers of Services, 5-000 Individual Support Options, and 6-000 Provider Operated/Controlled Community Based Residential and Day Service Option

175 NAC Health Care Facilities and Services Licensure - 3-000 Regulations and Standards Governing Centers for Persons with Developmental Disabilities

471 NAC Nebraska Medical Assistance Program Services - 2-000 Provider Participation

Neb. Rev. § 83-1201 through 83-1226 – Developmental Disabilities Services Act
Other Standard *(specify):*
The following standards are in addition to standards listed in above regulations and statutes.

DD provider staff delivering direct services and supports must:
Prepare and serve any appropriate meals and/or snacks to meet the individual's dietary needs, as documented in the service, nursing plan of care, or the individual's medical practitioner; and

Not be the legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS Division of Developmental Disabilities (DDD).
Frequency of Verification:
Every one or two years as applicable.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☑ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Service Coordination to waiver participants is provided by the Nebraska Department of Health and Human Services Division of Developmental Disabilities.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that

mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The requirement of obtaining background and/or criminal history is rooted in Neb. Rev. Statute 83-1217.01 and 404 NAC 4-004.03B.

a) The types of positions for which such investigations must be conducted.
Background and/or criminal history checks are conducted on each prospective DD waiver Medicaid provider by DHHS staff or Maximus, a vendor under contract with DHHS.

b) The scope of such investigations.
The state and federal background and/or criminal history checks are conducted by DHHS staff or Maximus which is a vendor under contract with DHHS. The background and/or criminal history checks consist of a review of the following:
NDEN - Nebraska Data Exchange Network for state and federal law enforcement history,
SOR - Nebraska State Patrol Sex Offender Registry,
DHHS APS and CPS Central Registries for any substantiated reports of adult or child exploitation, neglect, and abuse (physical, verbal, psychological or sexual),
OIG LEIE - Office of Inspector General List of Excluded Individuals and Entities
SAM - System for Award Management, formerly the Excluded Parties List System (EPLS)
SSDMF - Social Security Death Master File
NPPES - National Plan and Provider Enumeration System
MCSIS - Medicaid and CHIP Information Sharing System
PECOS - Provider Enrollment, Chain, and Ownership System
SAVE - Systematic Alien Verification for Entitlements Program
NMEP - Nebraska list of excluded parties

Certified DD agency providers must complete background and/or criminal history checks on each agency provider staff person or subcontractor that has direct contact with individuals served by the agency. Background checks must be conducted by providers within ten calendar days of employment and as necessary to verify a staff person is not on the registries. Employees who provide direct support services may not work alone with individuals served until the results of the registry checks and background and/or criminal history checks are reviewed by the provider. Alternative methods of background and/or criminal history checks approved by DHHS may be utilized by the provider to check a DD agency provider staff person or subcontractor that has direct contact with individuals served by the agency. The provider may employ a person pending the results of the background and/or criminal history checks if they have utilized an alternative method of background and/or criminal history checks at its own expense until the results are received. The results of each of these types of checks are directed to the certified provider agency for their use in making hiring decisions that adhere to applicable state regulations.

In addition to background and/or criminal history checks to ensure the appropriateness of individuals hired to provide services to vulnerable individuals, certified providers are required to comply with state laws that apply to using non-licensed persons providing medications and providing non-complex nursing interventions as delegated through the Nurse Practice Act to ensure their competency.

c) The process for ensuring that mandatory investigations have been conducted.
On-site certification review activities conducted by DDD staff ensure that required background and/or criminal history checks have been conducted by the DD provider agency. Provider management personnel are interviewed and records are reviewed to confirm that employee and subcontractor background and/or criminal history checks were completed. In addition, DDD staff review documentation of provider hiring decisions to verify adherence to applicable state regulations.

Once the background and/or criminal history checks are completed on potential non-specialized providers, Maximus notifies DHHS staff. Maximus will notify DHHS Program Integrity (PI) if a potential provider fails a screening or background check. PI will determine if a denial should be issued and if so, issue a denial letter to the potential provider and the referring DHHS staff. When the background check is “clean”, Maximus notifies the referring DHHS staff by e-mail and electronically transfers the enrollment data. The electronic enrollment data contains verification and dates that the background and/or criminal history checks were completed.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a) The entity (entities) responsible for maintaining the abuse registry.
The DHHS Adult Protective Services (APS) and Child Protective Services (CPS) Central Registries are maintained by employees of DHHS. The registry screenings are conducted by DHHS staff or Maximus which is a vendor under contract with DHHS, and consist of a check of the Nebraska State Patrol Sex Offender Registry (SOR), as well as the DHHS Central Registries for any substantiated reports of adult or child exploitation, neglect, and abuse (physical, verbal, psychological or sexual).

b) The types of positions for which abuse registry screenings must be conducted.
State Service Coordinators and all waiver providers who will provide direct contact services and supports, and any member of the provider's household if services will be provided in the provider's home undergo background and/or criminal history checks.

c) The process for ensuring that mandatory screenings have been conducted.
On-site certification review activities conducted by DDD staff ensure that required background and/or criminal history checks have been conducted by the DD provider agency. Provider management personnel are interviewed and records are reviewed to confirm that employee and subcontractor background and/or criminal history checks were completed. In addition, DDD staff review documentation of provider hiring decisions to verify adherence to applicable state regulations.

Once the background and/or criminal history checks are completed on potential non-specialized providers, Maximus notifies DHHS staff. Maximus will notify DHHS Program Integrity (PI) if a potential provider fails a screening or background check. PI will determine if a denial should be issued and if so, issue a denial letter to the potential provider and the referring DHHS staff. When the background and/or criminal history check is "clean", Maximus notifies the referring DHHS staff by e-mail and electronically transfers the enrollment data. The electronic enrollment data contains verification and dates that the background and/or criminal history checks were completed.

No contract is issued prior to completion of background and/or criminal history checks. See C-2-a above for additional information.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Licensed Center for Persons with Developmental Disabilities (CDD)	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

In Nebraska, the setting in which the individual lives is considered to be the individual's home, whether it is his/her family home, a participant-directed companion home, a provider operated group home, or a licensed Center for persons with DD(CDD) (this licensure is required for residential facilities that serve four or more individuals with DD). The facilities are single family homes and apartment complexes in residential neighborhoods and are indistinguishable from other houses, duplexes, condominiums, or townhouses. The homes have a kitchen with cooking facilities, breakfast nooks or small dining areas, living rooms, family rooms or dens, bedrooms, and single bathrooms. The person's bedroom, 'family room' or 'den' in the group home or licensed CDD allows for privacy, and visitors are welcome at times convenient to the individuals.

Individuals may decorate their personal space however they wish, and for common areas shared by more than one individual, input from each person is sought, and consideration is given to each person's needs, preferences, likes, and dislikes. The residential facilities are located in residential neighborhoods in the communities and have agency transportation or easy access to public transportation to visit friends, and participate in integrated and inclusive activities in their communities.

Two methods are utilized to monitor the home and community character - service coordination monitoring and quality review team monitoring.

Service Coordination monitoring -
DDD Service Coordination (SC) monitors the implementation of each IPP in its entirety twice annually in addition to the ongoing monitoring of the IPP which may involve specific areas of the IPP within each monitoring session. Full reviews are conducted at least twice annually on each person in services with ongoing monitoring conducted between the full monitoring.

One area that is monitored is the home environment. DDD service coordination staff observe the individual in his/her home and check Yes or No for the following indicators;
• Free from obvious safety hazards (ripped carpets, mold, offensive odors, and chemicals)
• Environment has been adapted to meet the person’s physical or behavioral needs
• General condition of home furnishing and/or personal belongings is in good repair (no holes in wall, broken doors/windows)
• access to a kitchen with cooking facilities and a dining area.

Quality Review Teams -
DDD has created a venue, known as Quality Review Teams (QRTs) through which families, guardians and advocates of people with developmental disabilities will interact with people served by certified DD service providers in their service environments and make recommendations to improve the quality of services. Oversight of the activities of quality review teams is a function of the DDD Central Office.

DDD contracts with an outside entity to develop and coordinate Quality Review Teams. The terms of the contract have been established to comply with the requirements of the Developmental Disabilities Services Act and ensure that activities of QRTs are available to individuals served by all certified community-based DD service providers.

The consultant coordinates the activities of the quality review teams, subcontracting with a local coordinator to establish the local team. The team members visit a person’s home and observe the environment, affect of individuals served, and interactions between individuals and staff persons. Quality review team members generate a written report after every on-site visit. They rate the agency in five areas: staffing, personal growth, regard for the individual, physical setting and safety using a (+) for positive impressions and a (-) for impressions that the agency needs to make improvements. If the team members don’t have strong feelings one way or the other about their impressions of a category, the category receives a rating of “N/A”. The report is written in narrative form and includes observations and recommendations. If something of concern is noted, it is expected that the agency respond in writing to the local coordinator.

Quarterly, the consultant submits to DDD central office:
1. Copies of each site report and the responses to those reports received from the provider agency;

2. An authenticated listing of the team members participating in each visit and a description of the role each team member fulfilled; and
3. A summary of the activities of the QRTs and consultant during the quarter just completed.
The reports must also include conclusions drawn by the consultant based on review of the individual site reports and provider responses received during the quarter.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Center for Persons with Developmental Disabilities (CDD)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Vehicle Modifications	☐
Vocational Planning	☐
Workstation	☐
Team Behavioral Consultation	☑
Personal Emergency Response System (PERS)	☐
Retirement Services	☑
Community Living and Day Supports (CLDS)	☐
Home Modifications	☐
Supported Integrated Employment	☐
Respite	☑
Assistive Technology and Supports (ATS)	☐
Integrated Community Employment	☐
Day Habilitation	☐

Facility Capacity Limit:

Capacity is limited by size of group home. The maximum capacity is fourteen.

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	

Standard	Topic Addressed
	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- ◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ○ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives, other than the waiver participant's parent, spouse, or child (biological, step, or adopted) or who are an immediate household member may be direct providers of Day Habilitation, Vocational Planning service, Workstation service, Integrated Community Employment, Supported Integrated Employment, Retirement services, Community Living and Day Supports, and Respite.

Relatives, other than the waiver participant's parent, spouse, or child (biological, step, or adoptive) may be indirect providers of Assistive Technology and Supports, Home Modifications, and Vehicle Modifications.

The State makes payment to relatives when it is determined the provider meets and maintains all standards and requirements outlined in applicable state regulations.

The provision of services by the relative is determined through documented team discussion during the planning process. The provision of services is monitored by the participant's state DDD Service Coordinator. This is determined on a case by case situation by the individual's service plan team. In rural areas, there may not be providers who are available or who have experience in working with individuals with DD. A relative may be available and would know the needs and preferences of the individual.

Determination that the above circumstances apply is determined by the participant and his/her team and verified during enrollment of the potential independent provider, prior to the issuing of a Service Provider Agreement.

The State does not make payments:
Directly or indirectly, to relatives who are the parent, spouse, or child (biological, step, or adopted) of the individual;
To members of the individual's immediate household, including relatives/legal guardians;
To a legally responsible relative/guardian,
For the routine care and supervision which would be expected to be provided by a family, or
For activities or supervision for which a payment is made by a source other than Medicaid.

There are no additional limitations on the amount of services just because the provider is a relative.

Waiver services are not intended to duplicate or replace other services or supports (paid or unpaid) that are available to the individual.

The following controls are employed to ensure payments are made only for services rendered:
The need for the service is documented in the individual service plan;
The provider is enrolled prior to the delivery of waiver services;
DHHS staff have prior authorized each waiver service to be delivered;
At the time that services are delivered, documentation is completed by the provider to support the delivery of the service, such as, but not limited to calendars, participant attendance records and agency staff time cards;
A claim and when applicable, supporting documentation, is submitted to DHHS for approval and processing; and
Edits are in place in the electronic systems.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Process for enrollment of certified DD agency providers is as follows:

DD service provider agencies are certified under applicable titles of the Nebraska Administrative Code. The certification process for DD agency providers is conducted by DHHS DDD staff.

DDD Central Office staff is responsible for certification and contracting of new agency providers. DDD Central Office staff routinely field inquiries by telephone, email, or written correspondence about becoming a certified agency

provider of community-based services for persons with developmental disabilities. DDD Central Office staff steer the caller to the DDD public website and provide verbal and written information to assist the interested party. These interactions may lead someone to develop a new service agency to increase the availability and choice of services and providers for persons with developmental disabilities.

DDD has developed an extensive web page for prospective providers which explains the process and has links to resource information. A provider orientation for interested parties is held at regularly scheduled times at least 3 times per year to describe the certification process and answer questions from the prospective providers. Attendance at an orientation session is required before the certification process can proceed.

Prospective providers are required to submit a letter of intent, application, and policy and procedural manual. At least two DDD staff persons will review the paperwork and provide feedback to the prospective agency. Once it is confirmed that the paperwork is complete and it addresses all of the state rules and regulations, communication is initiated to schedule contracting and certification. When all the necessary qualifications are met, the potential provider is informed that their agency has met DD provider agency certification requirements and are given provisional certification for six months. Towards the end of that six-month period, an on-site review will be conducted by the DDD certification team. If the new agency is deemed to have met and adequately address all rules and regulations in practice, it will be given either a one- or two-year certification.

The following is the process for enrollment of independent providers:

Information for becoming an independent non-specialized provider can be obtained from the waiver participant, his/her advocate, his/her legal guardian, or DHHS staff.

Following the development of the service plan, the individual, legal representative, and family, as appropriate, may work with the state DDD Service Coordinator and other designated DHHS staff to locate potential independent providers to deliver the services.

Individuals have the option of finding qualified individuals or agencies that are interested in providing non-specialized waiver services. Individuals often draw from their personal networks of applicable family members (i.e., not the parent, spouse, or child (biological, step, or adopted) of the individual, not living in the household, and who are not legally responsible), or friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students. Individuals utilize the internet as a resource for potential providers. Answers4Families is an internet family information and resource center, developed by DHHS in partnership with the University of Nebraska Center on Children, Families, and the Law. E-mail discussion groups are available and the directory (Nebraska Resource and Referral System) includes thousands of providers of services and supports in the state. Individuals interview the potential provider to determine whether the amount of experience, knowledge, and education or training will meet the consumer’s needs. The potential provider is referred to DHHS staff for enrollment. All willing and qualified providers can enroll.

DHHS staff and Maximus, a vendor under contract with DHHS, are responsible for enrolling independent providers as waiver providers. Upon receipt of a referral, DHHS staff enter the referral into Decision Point, the provider data management system, for the enrollment process. An application number needed for access to the Maximus web portal for enrollment is generated and DHHS staff send a referral packet to the potential provider. The referral cover letter advises the potential provider of the need to provide verification from other states they have lived in of their criminal history including any APS/CPS registry information from the other states. Verification of out of state background checks must be uploaded into the Maximus Decision Point web portal before the provider can enroll. The referral packet includes billing information, a Maximus application number and instructions on how to use the Maximus web portal to enroll, as well as a DD provider handbook, which contains general provider standards, specific service provider standards, and DD billing instructions. The potential provider completes the enrollment process with Maximus on line or, if requested, on paper. Maximus notifies the referring DHHS staff by e-mail and electronically transfers the enrollment data.

There is no timeline for enrollment of providers. The time it takes to enroll the potential provider is based on the potential provider’s participation in the enrollment process. When a provider is needed immediately, to the best of the State’s and the potential provider’s ability, the provider enrollment is expedited.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of certification reviews completed in a calendar year, the number of certification reviews that were completed prior to expiration.

Data Source (Select one):
Other
If 'Other' is selected, specify:
summaries of DD Surveyor/Consultant certification activities – SharePoint and/or Excel. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: With each certification review	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

Performance Measure:
Of the total number of certification/compliance reviews completed on certified provider agencies, the number and percent of providers that were recertified.

Data Source (Select one):
Other
If 'Other' is selected, specify:
summaries of DD Surveyor/Consultant certification activities – SharePoint and/or Excel. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: With each certification review	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service plan reviews, the number of service plan reviews that indicate the frequency and person responsible for each identified service is documented in the service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:

SC Supervisor service plan review – SharePoint and/or InfoPath. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: following each annual service plan team meetings	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the DD QI Committee and/or Deputy Director

Performance Measure:
Out of the total number of background checks completed on non-licensed/non-certified providers, the number of background checks completed prior to initial provider approval.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS provider referral/approval form – SharePoint or DecisionPoint. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each initial provider enrollment	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

Performance Measure:
Out of the total number of non-licensed/non-certified independent providers, the number of background checks completed that meet re-approval criteria.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS provider referral/approval form – SharePoint or DecisionPoint. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each annual provider reapproval	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of certified provider agencies, the number of agencies who were cited due to not have training records that indicate these staff have met initial orientation requirements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
summaries of DD Surveyor/Consultant certification activities – SharePoint and/or Excel. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: With each certification review	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Activities for the determination of compliance with the above sub assurances and performance measures is completed at the local level by the individual, the DDD SC, and the disability services specialist (DSS), and at the state level by DDD Surveyor/Consultants, DHHS staff, and Maximus, a vendor under contract with DHHS. Enrollment of qualified providers is completed by DHHS staff and Maximus. DHHS has the ultimate responsibility for enrolling qualified providers and the execution of Medicaid provider agreements. Monitoring of the delivery of services is conducted by the SC with input from the individual and/or representative when applicable. Certification activities are completed by DD Surveyor/Consultants.

Each DD provider agency is certified by DDD. DDD certifies providers in accordance with state regulations on an annual or biennial basis; depending on the results of the certification review (significant issues can lead to shorter certifications or termination of contracts to provider services). As a part of the certification process, checks are made to ensure providers are conducting services in accordance with state regulations, including ensuring training is occurring as specified in regulations and their policies and procedures, that they have a functional QI or QA systems and that they have a functional complaint mechanism.

Summaries of DDD on-site certification activities conducted by the certification teams are reviewed semi-annually by the DDS QI Committee. The DDD on-site certification summary includes the number of

certifications conducted and the frequency of compliance issues cited by type.

When the service is managed by the provider, the provider is responsible for furnishing training to their employees.

DDD contracts with certified DD provider agencies for services under this HCBS waiver. DHHS enters into a provider agreement/contract with non-certified independent providers. DDD does not require licensure or certification for independent providers that deliver non-specialized waiver services. All providers of waiver services must be Medicaid providers as described in the Title 471 regulations, and adhere to the same general conditions and standards. Failure to meet the regulatory requirements may result in termination or suspension of the provider agreement. Signing the provider agreement does not constitute employment.

Non-specialized waiver providers must meet the standards outlined in the approved waiver and in the state regulations. In addition to the general standards and conditions for all non-specialized waiver providers, there are specific standards that persons who provide particular types of waiver services must meet whether operating independently or through an agency.

Once DHHS approves the provider (Medicaid provider agreement and authorizations in place), the family trains the provider based on the service that will be provided and the specific needs of the individual and family. A Non-specialized Services Handbook is provided to each waiver participant and provider and includes information on the purpose and use of the handbook; an introduction to self-directed services; rights, responsibilities, and risks; developing a plan; finding providers; hiring providers; training providers; working with providers; personal safety; and monitoring the plan. The Non-specialized Services Handbook includes what standards and qualifications providers are expected to meet; an introduction for providers, respecting the individuals and families, general standards, standards for specific services, and information on authorization and billing.

Providers may receive information about becoming a provider from the waiver participant, his/her advocate, his/her legal guardian, or DHHS staff. All willing and qualified providers can enroll. DHHS staff and Maximus, a vendor under contract with DHHS, are responsible for enrolling independent providers as waiver providers. Upon receipt of a referral, DHHS staff enter the referral into Decision Point, the provider data management system, for the enrollment process. An application number needed for access to the Maximus web portal for enrollment is generated and DHHS staff send a referral packet to the potential provider. The referral packet includes billing information, a Maximus application number and instructions on how to use the Maximus web portal to enroll, as well as a DD Non-specialized Services Handbook, which contains general provider standards, specific service provider standards, and DD billing instructions. The potential provider completes the enrollment process with Maximus on line or, if requested, on paper. Maximus notifies the referring DHHS staff by e-mail and electronically transfers the enrollment data. Once enrolled, each independent provider of participant directed services is trained and directed by the waiver participant and/or their families.

The state QI committee reviews the data related to qualified providers quarterly and semi-annually. The committee meets quarterly and reviews reports on a variety of QI activities on a rotating, scheduled basis. Recommendations are made for action by appropriate parties, including DDD management, members of the committee, and other DHHS staff. The QI activities of DDD and results of reports are communicated by DHHS to provider organizations, the DDD Advisory Committee, the Nebraska DD Planning Council, and to individuals, families, and other interested parties.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When an issue with performance of an independent provider is identified, a plan to address the issue is discussed by the SC with the individual and family/advocate or with only the provider, depending on the issues that need to be addressed, and documented by the SC. The individual may address the provider or may ask their SC to assist in addressing the concerns or issues with the provider. The SC will follow through with the individual or on behalf of the individual until the issue is resolved.

The SC is responsible for facilitation and development of the service plan, and then monitoring the implementation of each service plan in its entirety twice annually in addition to the ongoing monitoring of the service plan which may involve specific areas of the service plan within each monitoring session. The SC

monitors and responds to whether the services documented in the service plan are authorized and provided; whether management of services, supports, and providers is occurring as documented, whether provider schedule generally follows the preference of the individual/legal representative, and whether the individual and/or legal representative are satisfied with the support of the independent providers. If utilized, the effectiveness of back up plans for the provision of services is also monitored.

Waiver participants may ask for assistance from their SC in communicating to their independent providers expectations, compliments, areas that need improvement, concerns, unacceptable practices, etc. The SC may increase monitoring activities, participate in discussions with the participant and provider, provide talking points, facilitate revisions to the service plan, or, upon direction from the individual, terminate the authorizations for that provider.

When a pattern is detected of inappropriate or inaccurate claims, a referral is made to the DHHS Program Integrity Unit.

DDD Service Coordination monitors the implementation of the service plan to ensure the timely and efficacious delivery of all services specified in the service plan for the person. Full reviews are conducted within 60 days of the annual and semi-annual service plans. Partial reviews are conducted on an ongoing basis, as a part of the ongoing monitoring process or in response to concerns brought up by the consumer, their family or others. The data is entered into a database, summarized, and reviewed by the DDD QI Committee quarterly. The summarized data for the service plan review and implementation data summary is shared with service coordination staff at the local level, providers and DDD Central Office staff.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually and/or as determined by the DDD administration

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

a) The waiver services to which the limit applies:
The total combined amount of ATS, home modifications, and vehicle modifications cannot exceed $5000.00 per the individual's waiver year.

b) The basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject

Based on analysis of data from other DHHS programs, research of other states that offer similar services and supports, and current data, the limits have been sufficient to assure the health and welfare of the waiver participants. The expenditures and utilization are tracked and the service plan is reviewed, at a minimum, semi-annually.

c) How the limit will be adjusted over the course of the waiver period
The state may adjust the limits during the period the waiver is in effect. The limits will be adjusted to take into account cost increases and will be periodically re-evaluated in light of changes in utilization patterns or other factors. The State will submit a waiver amendment to CMS to adjust the dollar amount.

d) Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state
When health and welfare needs cannot be met within the limits, adjustments, exceptions, or a referral to another HCBS waiver or non-waiver services and supports will be determined on a case by case basis. An exception request that includes justification for an adjustment to the limit may be made to DDD administration by the DD Service Coordinator.

e) The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs
The State has established the following safeguards to avoid an adverse impact on the participant - The participant is referred to another waiver that can accommodate the individual's needs, or the participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs.

f) How participants are notified of the amount of the limit
Participants are notified in writing by DHHS staff of the limits at the time of initiation of DD services and in the development of the service plan.

☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

a) The waiver services to which the limit applies:
The budget amount is the individually objectively assessed funding amount per the individual's waiver year and is determined by DDD staff. The total combined amount of ATS, home modifications, and vehicle modifications cannot exceed $5000.00 per the individual's waiver year and is not included in the individual's budget amount.

b) The basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject. The determination of funding for individuals is determined using the 'Objective Assessment Process' or OAP as stated in statute and regulations. Funding is assigned based on an objective assessment of each person's abilities, to provide for equitable distribution of funding based on each person's assessed needs. This process has been used since 1999 for persons new to services or requesting an increase in their funding. An individual's funding for respite, medical risk service, and behavioral risk service is not determined using an objective assessment process.

The assessment to ascertain each person's skills, abilities, and needs is the Inventory for Client and Agency Planning (ICAP). State staff completes the ICAP assessment with input from the individual's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation. This assessment is submitted to the DDD Central Office where the overall score is determined. An ICAP is completed for persons new to services, when a person adds either day or residential services or when they have a significant change in supports or abilities.

The individual's service coordinator is informed of the prospective individual budget amount. The SC shares this amount with the individual and their family or legal representative only. The individual's prospective budget amount is not open for public inspection.

c) How the limit will be adjusted over the course of the waiver period.
The state may adjust the limits during the period the waiver is in effect. The limit will be adjusted to take into account cost increases and will be periodically re-evaluated in light of changes in utilization patterns or other factors. The State will submit a waiver amendment to CMS to adjust the dollar amount.

d) Provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state.
The participant's health and welfare needs will be addressed by the team. Current services and the provision of services may be adjusted or additional waiver and/or non-waiver services and supports may be accessed. When health and welfare needs cannot be met within the limits, adjustments, or exceptions, or a referral to another HCBS waiver, non-waiver services and supports will be determined on a case by case basis. Additional funding may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. Based on input from the provider and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request an exception to the OAP. The amount of exception funding is determined administratively based on justification by the team of a temporary increased service need of the individual. To the base funding, determined by OAP, is added the cost of provider supports to mitigate any risks identified in clinical assessments.

e) The safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs.
The State has established the following safeguards to avoid an adverse impact on the participant:

Current services and the provision of services may be adjusted or additional waiver and/or non-waiver services and supports may be accessed.

The participant is referred to another waiver that can accommodate the individual's needs, or the participant is assisted in locating and obtaining other non-waiver services to assist in meeting his/her needs.

f) How participants are notified of the amount of the limit.
Participants are notified in writing by DHHS staff of the limits at the time of initiation of DD services and in the development of the service plan.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The HCB Settings transition plan is addressed in Attachment #2 HCB Settings, including how the State assessed the settings to determine whether they comport with the HCBS regulations.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Program Plan

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

A DHHS DDD Service Coordinator (SC) (case manager) is responsible to coordinate and oversee the delivery of effective services for individuals through assessment, service plan development, referral, and monitoring activities. The SC makes referrals and coordinates related activities to help an individual obtain needed habilitation services, medical, social, educational providers, or other programs and services, and may make referrals to providers for needed services and schedule appointments for the individual. The SC completes monitoring and follow-up activities with the individual, family members, providers, or other entities to ensure that the service plan is effectively implemented and adequately addresses the needs of the individual, and whether there are changes in the needs or status of the individual that warrant making necessary adjustments in the service plan and service arrangements with providers. The SC serves as liaison for the individual and family with service provider and the community.

The qualifications of a DDD SC are as follows:

Bachelor's Degree and professional experience in: education, psychology, social work, sociology, or human services, or a related field and experience in services or programs for persons with intellectual or other developmental disabilities is preferred.

Ability to mobilize resources to meet individual needs; communicate effectively to exchange information; develop working relationships with individuals with intellectual or developmental disabilities, their families, interdisciplinary team members, agency representatives, and individuals or advocacy groups; analyze behavioral data; monitor services and supports provided; apply DHHS and program rules, policies, and procedures; and organize, and evaluate, and address program/operational data.

Knowledge of current practices in the field of community-based services for persons with intellectual disabilities and other developmental disabilities; person-centered planning, ADA standards, self-direction, community integration, the principles of normalization; provision of habilitation services; positive behavioral supports; and statutes and regulations pertaining to delivery of services for individuals with developmental disabilities.

Knowledge of: the program resources/services available in Nebraska for persons with intellectual and other developmental disabilities; the objectives, philosophies, and functions of the Division of Developmental Disabilities; regulations governing the authorization, delivery of, and payment of community-based developmental disabilities services; Department of Education regulations; State statutes regarding persons with disabilities; and DHHS programs, such as Protection and Safety and public assistance programs.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The individual's DDD service coordinator provides support to the individual to actively lead in the development of their service plan. The individual also has the option to direct his/her service coordinator to facilitate the service plan development meeting so that the person may actively participate as a team member.

a) The supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process.
Information is provided by DDD staff at a local level to the individual, legal representative, and as applicable, their

family about services offered under the waiver program; the participant/guardian rights and obligations; due process rights; providers' roles and responsibilities; for applicable participant-directed service options, how to hire, fire, and direct providers; and claims review and verification processes. A Non-specialized Services Handbook is provided to each waiver participant and includes information on the purpose and use of the handbook; an introduction to self-directed services; rights, responsibilities, and risks; developing a plan; finding providers; hiring providers; training providers; working with providers; personal safety; and monitoring the plan. The handbook includes what standards and qualifications providers are expected to meet; an introduction for providers, respecting the individuals and families, general standards, standards for specific services, and information on authorization and billing.

Information is available on the DHHS public website, and is directly provided verbally and in written form prior to entry into the waiver services. When contacted, general information is provided by DDD central office staff.

b) The participant's authority to determine who is included in the process.
Persons eligible for DD services have a service plan developed prior to the initiation of waiver services. This person-centered and self-directed plan is individually tailored to address the unique preferences and needs of the person. Participants in the planning process will be determined by the individual and the legal representative, but must at least include the individual, representatives of specialized DD provider(s), the Service Coordinator, and the legal representative if there is one. The individual may raise an objection to a particular provider representative and the service plan team must attempt to accommodate the objection while allowing participation by provider representatives. The service plan must identify the needs and preferences of the individual and specify how those needs and preferences will be addressed. This must include identification of services and supports to be provided under the waiver program, as well as services and supports to be provided by other non-Medicaid resources.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Who develops the plan, who participates in the process, and the timing of the plan
The purpose of the annual service plan meeting is to determine waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the individual to achieve his/her future plan, or personal goals.

The purpose of semi-annual service plan meeting is to review the implementation of the annual service plan, to document the individual's future plans and personal goals, to explore how the team can assist the individual to achieve those goals, to determine what information is needed to develop appropriate supports to assist the individual to achieve future plans, to assign responsibility for gathering information if needed, and to review any other issues which have impact on the individual's and/or family’s life.

Persons eligible for waiver services have a service plan developed prior to the initiation of services and annually thereafter. This person-centered and self-directed plan is individually tailored to address the unique preferences and needs of the person. Participants in the planning process is determined by the individual and/or the family or legal representative, if applicable, but must at least include the individual, the service coordinator, the legal representative if there is one, and DD provider agency representatives when specialized DD services are provided. The service coordinator is responsible for scheduling, coordinating, and chairing all service plan meetings, and facilitating the participation of all team members. The service coordinator elicits and records facts and information from other team members, advocates for the person receiving services, encourages team members to explore differences and discover areas of agreement so that consensus can be reached, documents the service plan and the specific responsibilities of each team member with regard to implementation of services, supports, and/or strategies, and adheres to the electronic processes for service plan development and authorization. Meetings are scheduled at a time and place that accommodates the needs of the individual served, the legal representative of the person receiving services (if

applicable), the parent(s) (if the person desires parental involvement in the process), and the chosen advocate of the person receiving services (if applicable). Dates for regularly scheduled service plan meetings are scheduled well in advance to assure attendance by all team members. The person and/or family receiving services or any other team member of the interdisciplinary team may request a team meeting at any time.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status.

The service plan must identify the needs, goals, and preferences of the individual and specify how those needs, goals, and preferences will be addressed.
Assessments to support the service plan development are determined by the team and may include, but are not limited to, the Inventory for Client and Agency Planning (ICAP), Developmental Index, assessments completed by the specialized DD provider, if applicable, assessments completed during the participant's school years, if applicable, medical evaluations, and psychological reports.

(c) How the participant is informed of the services that are available under the waiver.
The participant is informed of the services that are available under the waiver prior to the initial plan development and annually thereafter at the pre-service plan meeting. Information about services is provided by DDD staff at a local level to the individual, legal representative, and as applicable, their family about services offered under the waiver program; the participant/guardian rights and obligations; due process rights; providers' roles and responsibilities; for applicable participant-directed service options, how to hire, fire, and direct providers; and claims review and verification processes. A handbook is provided to each waiver participant and includes information on the purpose and use of the handbook; an introduction to self-directed services; rights, responsibilities, and risks; developing a plan; finding providers; hiring providers; training providers; working with providers; personal safety; and monitoring the plan. The handbook includes what standards and qualifications providers are expected to meet; an introduction for providers, respecting the individuals and families, general standards, standards for specific services, and information on authorization and billing.

Information about services is also provided when funding is approved and upon request. Information is available on the DHHS public website, and is directly provided verbally and in written form prior to entry into the waiver services. When contacted, general information is provided by DDD central office staff.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences.
Prior to waiver entrance, an interdisciplinary team develops a detailed annual service plan through assessment, discussion, consensus, and assignment of responsibilities. The annual plan includes, as appropriate:
Employment goals and strategies when the youth is at least 16 years of age;
Medical information;
Nutritional considerations;
As applicable, physical nutritional management plans;
Adaptive devices, including support and protective devices;
Physical and nutritional supports;
Medical conditions and known allergies;
Medications;
Rights and rights restrictions;
Legal needs;
Finances;
Identification of basic and other needs, which include:

1. Physical survival
2. Physical comfort
3. Emotional well-being/happiness and personal satisfaction
4. Personal independence and self-care

Requested service(s);
Identification of current providers and a plan to locate needed provider(s), if applicable;
Description and schedule of strategies, services, and supports to be provided, taking into consideration individual's personal and career goals and identified needs;
Identification of the prospective budget amount and the projected monthly cost/utilization of the services and supports to be provided, as well as services and supports to be provided by other non-DD funded resources.
Back-up plan, for each participant-directed service, in the event non-specialized services can't be provided or aren't provided as scheduled.

The service plan indicates how the team believes that this plan will meet the health and safety needs of the individual. These needs may be met by a combination of specialized DD services/supports, non-specialized supports, natural supports, services/supports from other DHHS programs and other services/supports from other non-Medicaid sources. If it is determined that the needs cannot be met under the current plan without posing a threat to the health and safety of the individual, the team will re-consider the appropriateness of the individual receiving services through the waiver. This may require referral to other services or programs and the development of an alternate plan.

The SC's Supervisor ensures that the service plan addresses the individual's goals, needs (including health care needs), and preferences by reviewing and approving each service plan and budget authorization prior to implementation.

(e) How waiver and other services are coordinated.
Coordination of waiver services includes documentation, referral, and follow-up. The SC is responsible for coordination and oversight of the delivery of effective services for individuals through assessment, service plan development, referral, and monitoring activities. The SC along with the individual, legal representative, and as applicable, their family determines the level of coordination desired. The SC may make direct referrals and coordinate related activities to help an individual obtain needed habilitation services, medical, social, educational providers, or other programs and services, and may make referrals to providers for needed services and schedule appointments for the individual. The SC may provide information about referrals and resources to the individual, legal representative, and as applicable, their family.

The SC completes monitoring and follow-up activities with the individual, family members, providers, or other entities to ensure that the service plan is effectively implemented and adequately addresses the needs of the individual, and whether there are changes in the needs or status of the individual that warrant making necessary adjustments in the service plan and service arrangements with providers. When requested, the SC may serve as liaison for the individual and family with service provider and the community.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan.
The service plan document identifies the services and supports, schedule of delivery of services and supports, and responsibilities to implement the plan. The specialized DD provider agency representatives must participate in development of the service plan and take the necessary steps to ensure that the service plan documents the team review, discussions, and decisions. The service coordinator is responsible for monitoring the implementation of the plan by observing and documenting observations on the service plan monitoring form. Monitoring is completed at a minimum, within 60 days following the annual and semi-annual meetings and as opportunity arises.

(g) How and when the plan is updated, including when the participant's needs change.
At a minimum, the team comes together annually to develop the service plan, and semi-annually to review the service plan. The service plan is updated during the semi-annual service plan meeting, and when circumstances and/or needs change the service plan may be updated following discussion and agreement via an in-person, electronic, or written communication.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Assessment is required at least annually in conjunction with development of the service plan to identify the preferences, skills and needs of the person.

Strategies are developed by the team to address areas of risk that are identified through the assessment process. If, for example, it is identified through assessment that a person has the need to have their blood pressure monitored, the team would determine the method for ensuring such monitoring and informal teaching may be provided to enable the person to develop independence in the skills necessary to self-monitor. In addition to the informal teaching, the team would develop a strategy for inclusion in the service plan as a backup plan. The strategy specifies who will be responsible for monitoring the individual's blood pressure and how often it must be monitored.

The following is included in every service plan:
A description and schedule of waiver services and supports to be provided, taking into consideration the individual's goals, preferences and identified needs;
The identified provider(s);
A back-up plan for each non-specialized service, in the event non-specialized services can't be provided or aren't provided as scheduled. Back-up plans may include a temporary increase in natural supports, hiring additional on-call providers, etc.;
Documentation of how the team believes that this plan will meet the health and safety needs of the individual. These needs may be met by a combination of specialized and non-specialized services, supports, and strategies; natural supports, or services and supports from non-Medicaid programs.
Further assessment may be required based on the outcome of initial assessment. If the team identifies an elevated risk to the person's health and welfare due to risk-taking behavior or a medical condition, additional steps must be taken to address behavioral or medical risk.

When the team has attempted to manage a behavior unsuccessfully or feel they don't have the information necessary to develop an appropriate management plan, it may be appropriate for assistance from a DDD psychologist to be requested. If any of the following factors exist, a risk assessment should be considered after the team's attempts to manage the behavior have been unsuccessful:
The individual has committed at least one physical attack towards another individual with intent to inflict severe physical harm; or three moderately aggressive acts which may be described as kicks, blows and shoving that does not cause severe harm to another person.

The individual has had sexual contact/conduct with a child or non consenting adult or other vulnerable person; the sexual contact would include touching or fondling the person as well as physical penetration with a body part or implement or forcing that person to perform sexual acts on self.

The individual has committed severe property destruction with the potential for injury to others, including destruction by fire.

The individual has had illegal or unsafe social behavior towards others, including prostitution, confrontational theft or robbery, threatening another person with a weapon, kidnapping/false imprisonment, or child enticement.

The primary intent of a risk assessment is to help the team understand the variables which could increase risk so that the team can incorporate these into programming to reduce risk. Central office management may determine that behavioral risk services are necessary and oversee the selection of a behavioral risk service provider.
When medical risk is identified, the need for medical risk services will be determined by designated staff at central office. A referral is completed by the individual's service plan team to assist the team in planning, as a guide in giving adequate consideration to health and medical factors, or at the request of central office. When the team, which may include the individual's physician, believes that the individual's needs require medical risk services, the individual may be referred to DD central office for a formal health assessment by a DHHS Program Specialist RN. Medical history, current medical evaluations, and a formal health assessment are considered and recommendations or direction are provided to the team regarding optimal elements to consider when selecting or preparing service environments and treatment options that will best mitigate risks identified and support the individual. Central office management may determine that medical risk services are necessary and oversee the selection of a medical risk service provider.

If it is determined that the needs cannot be met under the current plan without posing a threat to the health and safety of the individual, the team may need to re-consider the appropriateness of the individual receiving his/her current waiver services. Current services and the provision of services may be adjusted or additional waiver and/or non-waiver services and supports may be accessed. When health and welfare needs cannot be met within the limits, adjustments, or exceptions, or a referral to another HCBS waiver, non-waiver services and supports will be determined on a case by case basis. Additional funding may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. Based on input from the provider and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request an exception to the OAP. The amount of exception funding is determined administratively based on justification by the team of a temporary increased service need of the individual. To the base funding, determined by OAP, is added the cost of provider supports to mitigate any risks identified in clinical assessments.

Back up arrangements for the delivery of residential or day habilitation services by the DD provider agency are described in the provider's policies and procedures. Each agency has on-call or substitute staff available when a staff person fails to appear for work. Agency staff and/or parents have contact information for the DD agency's Manager or

Coordinator who is responsible for scheduling and assigning on-call staff. Information about back-up plans for the delivery of residential or day habilitation services is provided by the DD provider agency to the individual and family or legal guardian when the DD agency provider is selected.

Back up arrangements for the delivery of non-specialized Community Living and Days Supports (CLDS) and Respite are determined on an individual basis. The need for and type of back up is discussed at the service plan meeting and documented in the service plan. Consideration is given to the natural supports that may be available to fill in and the availability of other enrolled providers in the community who could deliver services. Multiple independent providers may be enrolled as back up or substitute providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Nebraska's services for individuals with developmental disabilities are voluntary, both for the individual and the provider. Choice of providers and services is based on mutual consent.

Nebraska has regulations and processes in place to ensure individuals are provided information about DD services and providers to facilitate informed decisions. DHHS offices are located throughout the state to provide a statewide system of service coordination. The DHHS DDD public website includes information about the Division's responsibilities, service coordination, services funded by DHHS and DDD, certified DD provider agencies, and non-certified independent non-specialized providers as well as links to other resources for individuals and families.

The service coordinator provides the individual, and/or the family or legal representative, if applicable, information about or web addresses or links to local community services and supports, service coordination, services funded by DHHS and DDD, currently certified DD provider agencies, and non-certified independent non-specialized providers.

Information about local community services and supports, and how to access available services is provided to participants. Answers4Families is an internet family information and resource center, developed by DHHS in partnership with the University of Nebraska Center on Children, Families, and the Law. E-mail discussion groups are available and the directory (Nebraska Resource and Referral System) includes over 8,000 providers of services and supports in the state. Feedback on the site can be given instantly, with corrections the next business day, and every resource is updated every six months.
Ready, Set, Go! is a web-based series of materials and resources intended to assist in making decisions about supports for young adults with intellectual or developmental disabilities as they move from high school to adult life.

Some local Arcs, in collaboration with local public school's Special Education departments, Vocational Rehabilitation services, and Service Coordination offices also co-sponsor a "Provider Fair." Provider Fairs give the individual and his/her family/legal guardian an opportunity to meet area DD provider representatives and ask questions about philosophy, services, supports, etc. The DD provider agencies hand out marketing materials and direct interested parties to their websites, and DDD representatives provide and the DHHS DDD public website address and written materials about services provided by independent providers, such as the types of services and the provider standards.

Service coordination staff may assist the individual, family, and/or legal guardian to arrange interviews with potential providers. Service coordination staff may assist the individual, family, and/or legal guardian to arrange tours of potential specialized DD agency providers.
Families often draw from their personal networks of family members not living in the household, friends, neighbors, teachers, paraprofessional/teacher's aides, church members, and local college students in order to select non-specialized providers.

When the individual is considering home modifications, the SC makes a referral to an approved provider to ensure that the referral is an appropriate modification, based on the service definition of the applicable service and the provider's established protocols.
Home modification service includes:
An assessment report, which is a summary of needs and current support; recommendations; cost estimate and cost coordination, if needed; and hiring and oversight of subcontractor;
If applicable, documentation of the orientation to and training on how to use the assistive equipment/support, which

may include the delivery and/or installation dates;
Copy of signed subcontractor bill and signed consumer acceptance form; and
Narrative summary.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Health and Human Services is the state Medicaid agency for Nebraska. All functions related to service plan approval are completed by DHSS staff.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare.
Service coordination is responsible for in-person, on-site monitoring of individual health and welfare and monitoring of the implementation of the service plan.

(b) The monitoring and follow-up method(s) that are used.
Monitoring and follow-up methods include:
Documenting observations made during a planned monitoring visit or unscheduled visits.

A review of all components of the service plan to ensure:
Delivery of services, supports, and strategies in accordance with the service plan, with additional monitoring of behavioral risk services or medical risk services if applicable;
Individual access to wavier and non-waiver services identified in the service plan;
Free Choice of provider(s);
Services meet individual/family needs;
Effectiveness of back-up plans, if applicable and utilized;
Individual health and welfare; and
Physical nutritional management.

Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the service plan is necessary.

A semi-annual review of the service plan by the SC and the team in-person. The team must review progress, implementation of the service plan, and the need for any revisions to the service plan.

Addressing concerns with the provision of services.

Follow-up and remediation process for issues discovered during monitoring:
Observations made during a review or "in passing" are documented. Should immediate safety concerns be evident, the concern will be expressed verbally to appropriate persons to prevent the individual served or others from being harmed. If it is necessary for the SC to intervene to ensure the health and/or safety of the individual, such incidents will be immediately discussed with the SC supervisor. Suspected abuse or neglect will be reported to DHHS Adult Protective Services and Child Protective Services as appropriate. Documentation will be completed.

Service coordination observations during the delivery of participant-directed non-specialized services of Respite and Community Living and Day Supports are discussed with the individual and/or family, as appropriate, and the provider, as appropriate, as soon as possible, and followed through to resolution. If resolved at this level, resolution will be documented on the monitoring tool or in service coordination narratives. A team meeting may be called to respond to monitoring issues and to adjust the service plan if necessary.

When a pattern is detected of inappropriate or inaccurate claims, a referral is made to the DHHS Program Integrity Unit.

Specialized services are provider operated and include group home residential service, Integrated Community Employment, Behavioral Risk, Day Habilitation, Companion Home Residential service, Extended Family Home Residential service, In-Home Residential service, Medical Risk, Vocational Planning service, Supported Integrated Employment, Workstation service, and Team Behavioral Consultation. Observations during the delivery of specialized services will be discussed with appropriate provider agency staff as soon as possible. If resolved at this level, the resolution is documented in the SC narratives. If the issue is not resolved, the SC will complete a Service Review Memo and send to the provider agency staff supervisor and the SC's supervisor (SCS). A response is requested within ten days from receipt of the memo.

When a written response is received, the SC will review it to ensure that the action taken will correct the problem. If the response is not adequate or no response is received, the SC will contact the person to whom the form was sent to find out the status of the response. 1) If the response was inadequate, the SC may add comments made by the staff person to the response. If the response is still inadequate, the SC will copy the written documentation of noted concerns and send it to his/her immediate supervisor. 2) If no response was received and the staff person indicates when a response will be sent, the SC will use his/her judgment to determine whether to keep the form until the response is received or whether to copy the documentation and forward it to his/her immediate supervisor. The SC's supervisor will address the issue with the supervisor of the provider agency staff responsible for making changes or corrections to alleviate the concerns. The SCS will notify the SC with the results of the contact and the SC will document in the narratives. The issues must be addressed in writing. A response within ten days will be requested if the issue has not been resolved. When a response is received, the supervisor and SC will review the response to ensure that it meets the expectations in correcting the problem. If no response or an inadequate response is received, the SCS will copy the written documentation of noted concerns and send it to the Administrator of Services (AS) or their designee.

The AS or designee will contact the Area Director of the provider agency to develop a mutually agreed-upon plan of action. If no resolution is achieved, or if trends show that the problems are recurring (such as "no ongoing habilitation provided," "programs not run as written," "programs not run at all," etc.) the AS or designee will inform the DDD

Central Office of the problems. Central Office staff will review the concerns to determine what steps to take and will notify the AS or designee. Central office staff may provide consultation/technical assistance to the DD provider agency, perform a focused certification or contract compliance review specific to the delivery of services to an individual or provider setting, or complete a complaint investigation.

During certification reviews conducted by DDD Surveyors, the service plan is reviewed using the Core Sample Record Audit and, if behavior modification is a part of the service plan, the Core Sample Review Checklist. Certification reviews are conducted annually, biennially, or as determined by DDD management staff.

In addition, the service plan is reviewed annually to determine if the plan developed by the individual's team meets the individual's needs and also to determine if services are implemented in a manner that meets the individual's needs. Areas of services reviewed for example are health, safety, habilitation, and personal goals. The service plan identifies services, supports, interventions, and strategies to be provided by the specialized DD provider agencies as well as services provided by non-specialized independent providers of DD services. When non-compliance issues are identified with the provider agency, the types of action that may be taken range from citing a deficiency to termination of the provider agency. The general action taken is a citation of a deficiency and the provider must provide an acceptable plan of improvement that addresses the issues cited for those individuals identified in the sample as well as address the issue cited on a system level within the specialized provider.

The information derived from monitoring the implementation of the service plan and review of the service plan is entered into a database. Designated DHHS staff has access to the database and may query the data to identify problems and trends.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service plans with identified behavioral risks, the number of service coordination monitorings that indicate the behavioral risks are being addressed as documented in the service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC monitoring tool – SharePoint and/or InfoPath. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: following each annual and semi-annual service plan team meetings	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually or as determined by the DD QI Committee and/or Deputy Director

Performance Measure:
Of the total number of service plans with identified accessibility needs, the number of service coordination monitorings that indicate the adaptations were made.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC monitoring tool – SharePoint and/or InfoPath

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: following each annual and semi-annual service plan team meetings	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the DD QI Committee and/or Deputy Director

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service plans, the number of service plans that had an Individual/Family meeting as documented in the Personal Focus Worksheet of the service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Supervisor service plan review – SharePoint, Therap, and/or InfoPath. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each review of the service plan	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: or as determined by the DD QI Committee and/or Deputy Director

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service plans, the number of service plans that were developed by the team annually.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Supervisor service plan review – SharePoint, Therap, and/or InfoPath. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: following each annual service plan team meeting	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Semi-annually or as determined by the DD QI Committee and/or Deputy Director

Performance Measure:
Of the total number of service plans developed each year, the number of service plans that were reviewed semi-annually to assess a change in a person's needs.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Supervisor service plan review – SharePoint, Therap, and/or InfoPath. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each review of the service plan	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: or as determined by the DD QI Committee and/or Deputy Director

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service coordination monitorings, the number of service coordination monitorings that indicate services are being delivered as authorized in the State's electronic billing system.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Supervisor service plan review – SharePoint, Therap, and/or InfoPath

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each review of the service plan	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the DD QI Committee and/or Deputy Director

Performance Measure:
Of the total number of approved service plans, the number of plans that reflect services were authorized as specified in the plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Supervisor service plan review – SharePoint, Therap, and/or InfoPath

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each review of the service plan	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the DD QI Committee and/or Deputy Director

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new waiver participants each year whose records contain an appropriately completed and signed Consent/Request for Services form which offered a choice between institutional and waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Supervisor service plan review – SharePoint, Therap, and/or InfoPath. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each review of the service plan applicable to the initiation of this waiver	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination worksheet – SharePoint, Therap, and/or InfoPath. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each initial waiver eligibility determination	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

Performance Measure:
The number and percent of new waiver participants or their legal guardian if applicable, that participated in making a choice of waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination worksheet – SharePoint, Therap and/or InfoPath

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each initial waiver eligibility determination	

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Supervisor service plan review – SharePoint, Therap, and/or InfoPath. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each review of the service plan applicable to the initiation of this waiver	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: or as determined by the DD QI Committee and/or Deputy Director

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
In Nebraska, the service plan for participants of this waiver is known as the Individual Program Plan (service plan) or Individual Supports Plan (ISP). The DDD Service Coordinator (SC) is responsible for facilitation and development of the service plan.

The SC Supervisor reviews the initial service plan and each annual service plan for each waiver participant to ensure it meets the waiver and regulatory standards. The process was developed to also ensure the service plan is completed in accordance with timelines and to aggregate the results to identify issues at various levels of the DDD.

The DDD staff considers assessment information, the individual's personal goals, and the service plan to determine if the services defined flow from the assessments and personal goals. This review includes not only the waiver services, but also the non-waiver services and other natural and community supports identified in the service plan.

If issues (i.e. institutionalized more than 30 days, loss of Medicaid eligibility, failure to utilize waiver services or failure to address health and safety requirements) are identified that will affect the waiver status of the individual, the SC is notified and given a date to respond. Failure to receive corrections may result in the removal of the person from the waiver and notification to the SC supervisor. Correction of the areas of concern

may allow the person to be maintained on the waiver or to be put back on the waiver, if they had lost their waiver support. Other issues that do not effect waiver funding are passed along to the SC responsible for the development of the service plan.

To allow for increased state oversight of the service plan review process, the responses are entered into a database. The database allows for individual Disability Services Specialists and SC Supervisors to have access to the information in aggregate form to look at the performance of individual service coordinators. This information is reviewed and acted on, as appropriate, at the local level.

In addition, the SC monitors the implementation of each service plan in its entirety twice annually in addition to the ongoing monitoring of the service plan which may involve specific areas of the service plan within each monitoring session.

In this way, there is an extensive 100% review of the design and the implementation of every service plan for persons receiving waiver services. Monitoring mechanisms include -
1. A review of all components of the service plan to ensure delivery of services as specified by the service plan;
2. Initiation of any action necessary to ensure the delivery of services and progress toward achieving outcomes. Necessary action includes reconvening the team if a change in the service plan is necessary; and
3. A semi-annual review of the service plan by the service coordinator and the service plan team. The team reviews progress, implementation of the service plan, and the need for any revisions to the service plan.

The monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitorings, the SC conducts ongoing monitoring. During each of these monitoring sessions, the SC may scrutinize only some of the items on the monitoring form. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

To allow for state oversight of the Service Coordination monitoring process, responses on the service plan monitoring forms are currently entered into a web-based database. This allows individual SCs to track issues that aren't resolved and provide aggregate information for SC Supervisors, the Administrator of Services, and the DDD central office. The information is useful to the Supervisors and Administrator for looking at the performance of individual service coordinators and providers, as well for identifying any area wide issues. This information is reviewed and acted on, as appropriate, at the local level.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
If issues are discovered that will affect the waiver status of the individual, the SC is notified and given a date to respond. The date of response is determined by the SC supervisor and varies between 5 working days and 10 working days, based on the nature of the issue. Failure to receive corrections may result in the removal of the person from the waiver and correction of the areas of concern may allow the person to be maintained on the waiver or to be put back on the waiver, if they had lost their waiver status. There is no gap in services to the participant; services are funded by state general funds to ensure continuation of services, health, and safety.

The SC monitoring process is designed to review the implementation of the total plan after both the annual and semi-annual team meetings. Between these full monitoring opportunities, the SC conducts ongoing monitoring. During each of these monitoring sessions, the SC may scrutinize only some of the items on the monitoring form. This will allow for focused monitoring if issues have been raised or are noted during the time of the monitoring.

To allow for state oversight of the SC monitoring process and the service plan review process, the responses are entered into a web-based database. This allows individual SCs to track issues that aren't resolved and provide aggregate information for SC Supervisors, the Administrator of Services, and the DDD central office. The information is useful to the Supervisors and Administrator for looking at the performance of individual service coordinators and providers, as well for identifying any area wide issues. This information is reviewed and acted on, as appropriate, at the local level.

When issues or problems are discovered during a SC monitoring, the individual's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the individual, manager of services, and/or providers, etc. A

timeline to address the issues and/or a service plan team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

When a pattern is detected of inappropriate or inaccurate claims, a referral is made to the DHHS Program Integrity Unit.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the SC Administrator, the state DDD QI committee, or the DDD Deputy Director

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) The nature of the opportunities afforded to participants
DDD embraces a self-directed philosophy, designed to provide choice when determining the services and supports that are needed to maximize the independence of the person with an intellectual or other developmental disabilities. The service coordinator is involved in supporting participant direction. The SC supports participant direction by meeting with the individual and family to facilitate discussion of the individual's budget, the participant directed services available to the individual, and responsibilities associated with choosing participant directed services. The SC may assist in locating independent providers and facilitate interviewing the perspective providers, and may assist in setting up referral meetings with certified DD provider agencies. The SC facilitates and documents the service plan meeting.

Opportunities for participant direction are available to individuals that choose non-specialized DD services and some specialized DD services delivered by certified DD provider agencies. Non-specialized services are services directed by the individual or guardian, or when the individual has selected a family advocate. Family/guardian-directed or participant-directed services are intended to give the individual more control over the type of services received as well as control of the providers of those services.

The underlying philosophy of offering non-specialized participant directed services is to build upon the individual and family strengths and to strengthen and support informal and formal services already in place. Non-specialized participant directed services include Respite and Community Living and Day Supports. When specialized services are chosen, participants have the opportunity to choose their Extended Family Home provider and choose their house mates when Companion Home service is selected. When applicable, participants choose their roommates and personal activities, participate in scheduling mealtimes and activities with house mates, participate in setting general house rules, and determine their personal schedules when Group Home or Extended Family Home service is selected.

(b) How participants may take advantage of these opportunities
Persons eligible for waiver services participate in development of their service plan prior to the initiation of services and annually thereafter. The purpose of the annual service plan meeting is to determine waiver and non-waiver services, interventions, strategies, and supports to be provided to assist the individual to achieve his/her future plan, or personal goals. The purpose of semi-annual service plan meeting is to review the implementation of the annual service plan, to document the individual's future plans and personal goals, to explore how the team can assist the individual to achieve those goals, to determine what information is needed to develop appropriate supports to assist the individual to achieve future plans, to assign responsibility for gathering information if needed, and to review any other issues which have impact on the individual's and/or family's life. The person and/or family receiving services or any other team member of the interdisciplinary team may request a team meeting at any time between the annual and semi-annual meetings to update the service plan when circumstances and/or needs change.

The individual has the right and responsibility to participate to the greatest extent possible in the development and implementation of his or her plan. This person-centered service plan is individually tailored to address the unique preferences and needs of the person. Participants in the planning process are determined by the individual/family or the legal representative, if applicable, but must at least include the individual/family, the service coordinator, the legal representative if there is one, and DD provider agency representatives when specialized DD services are provided. The participant may take responsibility or direct their SC to be responsible for scheduling, coordinating, and chairing all service plan meetings. The SC assists the participant or directly facilitates the participation of all team members. The service plan must identify the needs and preferences of the individual and specify how those needs will be addressed. This must include identification of services and supports to be provided as well as services and supports to be provided by specialized (i.e. provider operated) services and other non-DDD funded resources.

Individuals and/or their families have the right and responsibility to select potential independent providers as well as specialized DD provider agencies. The individual and/or their family identifies a potential independent provider and screens the provider to determine capability for delivery of non-specialized services, based on the waiver participant's needs and preferences, and the potential provider's experience, knowledge, and training; and describes to the provider

the supports to be delivered. The individual and/or their family identifies a potential certified provider agency and screens the provider to determine capability for delivery of specialized habilitation (teaching and supporting) services, based on the waiver participant's needs and preferences, and the potential provider's experience.

(c) The entities that support individuals who direct their services and the supports that they provide.
Once the potential non-specialized provider is identified and screened, the individual or family contacts their service coordinator or designated DHHS staff to request enrollment of the provider. At any time, the individual or his/her family can request assistance from the SC. The service coordinator may complete the above steps, as directed by the individual and/or family.

Once the non-specialized provider is enrolled and prior authorized for delivery of services, the individual and/or family directs the provider by setting the schedule and determining how the services will be delivered, and, based on the service plan, the type and amount of service.

The individual also has the authority to "fire" the provider, by directing DHHS staff to end the authorization for the delivery of non-specialized services. DHHS has the option to retain the contract to allow other individuals to utilize the enrolled provider.

The DHHS is appointed the employer's agent as a means to ensure all requisite IRS rules are being followed. The participant or legal representative signs a form to appoint the state as the employer's agent. This form is maintained by DHHS and kept in the participant's file in a DHHS office. Information regarding IRS related responsibilities is explained verbally and in writing to the participant and provider. Participants are not liable for tax liabilities.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [x] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [x] **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

  Group homes with four or more unrelated persons with DD, licensed as a Center for persons with Developmental Disabilities.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Additional criteria that excludes participant-direction:

Person chooses specialized intermittent or continuous services that are controlled and operated by the DD provider.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) The information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction
Information about participant direction opportunities is available to individuals who are currently receiving DD services as well as to any individual entering DD services. Information is provided to the individual prior to entrance to the waiver and prior to the annual service plan development meeting to allow sufficient time for the participant to weigh the pros and cons of participant direction and obtain additional information as necessary. Information about participant direction opportunities is available in a nonspecialized services handbook, pamphlet, the DHHS web site, and other public communications, such as information from Nebraska Department of Education about post high school opportunities and information developed through the Nebraska DD Council.

The nonspecialized services handbook is utilized as a training tool and post-training reference guide for individuals and his/her support system. The handbook includes the purpose of the handbook, an overview of non-specialized services, and tips for determining the appropriateness of participant directed services and supports, developing a plan, and putting the plan into action. The handbook also includes tips for finding the right provider, provider and service standards, participant liability (e.g. participants are not liable for tax liabilities), preparing for an emergency, and additional resources. Billing and authorization guidelines for providers and how to fill out and submit a claim is also included in the nonspecialized services handbook.

(b) The entity or entities responsible for furnishing this information
The DHHS DDD public website includes information about the Division’s responsibilities, service coordination, services funded by DHHS and DDD, certified DD provider agencies, and non-certified independent non-specialized providers as well as links to other resources for individuals and families.

The service coordinator provides the individual, and/or the family or legal representative, if applicable, information about or web addresses or links to local community services and supports, service coordination, services funded by DHHS and DDD, currently certified DD provider agencies, and non-certified independent non-specialized providers.

(c) How and when this information is provided on a timely basis.
The provision of written information about participant - directed services and supports is an integral component of the development of the service plan. The participant's service coordinator provides verbal and written information about participant - directed services and supports to individuals and families at entry into waiver services, annually thereafter and as requested.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appointment of a representative is a voluntary appointment and the representative is appointed by the participant or legal representative. The responsibilities and extent of decision making authority exercised by the representative is determined by the participant and his/her team and documented in the service plan.

Service coordination provides monitoring to ensure that the representative functions in the best interest of the participant.

The representative cannot also be paid to provide waiver services to the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Retirement Services	☑	☐
Community Living and Day Supports (CLDS)	☑	☐
Respite	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- ○ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

  Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

  - ☐ **Governmental entities**
  - ☐ **Private entities**

- ◉ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

Answers provided in Appendix E-1-h indicate that you do not need to complete this section.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

All DD service coordinators are qualified to provide self –direction guidance. In addition to the basic service coordinator training, DD SCs receive training on the self-directed services that are available, such as the types/definitions of services; limits on the amount, frequency, or duration; authorization codes and rates; billing guidelines; budget projecting; and the referral process for enrollment of independent non-specialized providers. The SCs also receive the Non-specialized Services Handbook as a training tool.

In addition to the basic service coordination duties performed by DDD service coordinators, the DDD SC provides supports for those who self-direct Community Living and Day Supports, Retirement services, and/or Respite services. The SC will review the Non-specialized Services Handbook with the participant and their representative if applicable to assist the individual in understanding their responsibilities in hiring, training, screening claims, and dismissing a provider, as well as assisting the individual to recognize potential abuse and neglect situations.

The SC will provide the amount of funding available to the participant and develop the monthly budget with the participant and representative. When determining the rate for an independent provider, the service coordinator and participant and/or representative develop the budget together. The participant is informed of their annual funding allocation and the range of rates to be considered, based on the potential provider's experience and training, and the participant's needs and tasks that the potential provider will perform.

If the participant has not chosen their provider(s), the SC may provide a list of currently enrolled independent providers for the participant to select from, and interview the potential provider with the waiver participant if the participant requests assistance. The SC follows through with DHHS staff responsible for provider enrollment to ensure that the provider is enrolled and authorized to provide the selected services to the participant.
If requested the SC will assist the waiver participant in communicating to the independent provider his/her expectations of what and how the services will be delivered as well as any performance issues that may arise.

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Vehicle Modifications	☐
Vocational Planning	☐
Workstation	☐
Team Behavioral Consultation	☐
Personal Emergency Response System (PERS)	☐
Retirement Services	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	☐
Community Living and Day Supports (CLDS)	☐
Home Modifications	☐
Supported Integrated Employment	☐
Respite	☐
Assistive Technology and Supports (ATS)	☐
Integrated Community Employment	☐
Day Habilitation	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Nebraska's DD services are voluntary services, for the participant as well as the provider. Each person's funding amount is based on an objective assessment process, and each participant or his/her legal guardian can choose the types of services and the providers to meet their needs and preferences. The authorization of funding for services to a particular provider or providers is mutually agreed upon, and either entity can end participation. All DD providers are waiver providers.

Funding is determined using an objective assessment process, and the funding follows the individual.

Nebraska offers provider managed services under this waiver and another HCBS waiver for adults with developmental disabilities. The individual or his/her legal guardian may choose provider managed services that may better meet their health and safety needs. The provider managed waiver services are delivered by certified DD provider agencies and the

team process is utilized in assisting the individual or legal representative in choosing waiver services and providers that may better meet his/her needs. Individuals can receive other waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

State regulations allow the state to deny or end funding of specific services when:

An individual's needs are not being met through waiver services or intensity of services and supports does not reflect the need for ICF level of care.

The individual or legal representative has failed to cooperate with, or refused the services funded by DDD; or,

The individual's service plan has not been implemented.

The decision to end funding may be based on Service Coordination monitoring, review of the individual program plan, critical incident reports, and assessment of risk to the individual and/or community, and complaint investigations conducted by the DHHS staff.

Nebraska offers provider managed services under this waiver and another HCBS waiver for adults with developmental disabilities. The individual or his/her legal guardian may choose provider managed services that may better meet their health and safety needs. The provider managed waiver services are delivered by certified DD provider agencies and the team process is utilized in assisting the individual or legal representative in choosing waiver services and providers that may better meet his/her needs. Individuals can receive other waiver services without a gap in the provision of services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	400	
Year 2	525	
Year 3	650	
Year 4	775	
Year 5	925	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law

employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- ☑ **Recruit staff**
- ☐ **Refer staff to agency for hiring (co-employer)**
- ☑ **Select staff from worker registry**
- ☑ **Hire staff common law employer**
- ☐ **Verify staff qualifications**
- ☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- ☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- ☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☑ **Determine staff wages and benefits subject to State limits**
- ☑ **Schedule staff**
- ☑ **Orient and instruct staff in duties**
- ☑ **Supervise staff**
- ☑ **Evaluate staff performance**
- ☑ **Verify time worked by staff and approve time sheets**
- ☑ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Initially, annually, and with each written notice of decision, the individual and his/her legal representative are informed of and receive a copy of the right to appeal. Under this waiver, the written notice of action is known as the Notice of Decision. A written notice of any decision made by DDD staff is sent to the participant and/or legal representative.

Notice to an individual must be made of an adverse action under the following circumstances:
The individual does not meet the eligibility criteria for HCBS waiver;
Institutional services are chosen over HCBS waiver;
Chosen provider does not meet qualifications; and
Denial, reduction, suspension, or termination of services.

The service coordinator and the disability services specialists provide written and verbal information to individuals. Included in the information provided are assurances that services will continue or be reinstated should the adverse action be contested by requesting an informal dispute resolution (IDR) meeting or a fair hearing.

Notices of adverse action and the opportunity to request a fair hearing are kept in SharePoint, the electronic individual service coordination file, and/or in OnBase, the electronic eligibility file.

As applicable, the participant's rights are translated and provided in their primary language.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

(a) The State agency that operates the process.
DHHS DDD operates the dispute resolution process, known as an Informal Dispute Resolution (IDR) process. When requested by the individual or his/her legal representative, an IDR meeting may be arranged in accordance with state regulations. Any decision regarding the individual's eligibility or funding for services may be disputed by the individual or legal guardian. The issues usually disputed include ineligibility for DD-funded services, denial of immediate funding, or denial of an increase in funding for services currently being provided.

IDR meetings are facilitated by DDD central office staff acting on behalf of the DDD Deputy Director. The participant is informed in writing annually that the informal dispute resolution is not a pre-requisite for a Fair Hearing. The state regulations are available to the individual and legal guardian upon request.

(b) The nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process.
The request for an IDR meeting, if requested within 90 days of receiving notice of the decision being disputed, stays the adverse action as well as the deadline for filing an appeal, or fair hearing. Informal dispute resolution meetings are scheduled promptly and at the convenience or the complainant or their authorized representative. The IDR meetings are generally held via conference call but may also be held in person, generally in the local DHHS office.

Participation in an IDR is generally by the individual and/or their authorized representative, and a DDD representative, which may be a Disability Services Specialist (DSS), a DSS Supervisor, or a DD Administrator. The DDD representative explains the eligibility and funding process, hears the complaint, gathers any additional information, and explains the next steps in the IDR process, the person's further appeal rights, and timelines. The individual and/or their authorized representative may invite provider staff or advocates and all are encouraged to offer their perspectives regarding why the decision should be affirmed or reversed. The circumstances of the original situation are reviewed and additional information is often obtained, which is then reviewed by the DDD Deputy Director or designee, and the original decision is either affirmed or reversed.

A notice of the IDR decision is sent to the individual and/or their legal representative within one business day of the decision. The IDR decision notice includes their due process rights and when applicable, the remaining number of days to request a fair hearing. When the decision is reversed, a new Notice of Decision is completed and is sent with the IDR decision notice.

(c) How the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process.
The individual and/or their legal representatives have the option of continuing on to the formal appeal hearing or dropping their request.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDD defines incidents as allegations or occurrences of abuse, neglect, and exploitation; events that cause harm to individual; events that serve as indicators of risk to participant health and welfare; and public complaints related to providers or participants.

All suspected abuse and neglect reportable under Nebraska state statutes are required to be reported to DHHS Protective Services or law enforcement. Suspected abuse and neglect may be reported to DHHS by a toll free abuse and neglect hotline that is available 24/7 and posted on the DHHS website. Reports of suspected abuse and neglect are also accepted by e-mail, FAX, or letter.

In addition, under state policies, all incidents, including allegations of abuse and neglect reportable under Nebraska state statutes are currently required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using the Department approved format, Therap, within 24 hours of the verbal report. A written summary must be submitted via Therap to the Department of the provider's investigation and action taken within 14 days. An aggregate report of incidents must be submitted to the

Department on a quarterly basis. Each report must be received by the Department no later than 30 days after the last day of the previous quarter. The reports must include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that result in a reduction in the number of incidents over time.

Currently in Nebraska, abuse means any knowing, intentional, or negligent act or omission on the part of a caregiver, a vulnerable adult, or any other person which results in physical injury, unreasonable confinement, cruel punishment, sexual abuse, exploitation, or denial of essential services to a vulnerable adult.

Exploitation is means the taking of property of a vulnerable adult by means of undue influence, breach of a fiduciary relationship, deception, or extortion or by any unlawful means.

Restraint means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement or normal functioning of an individual. Includes medication used solely to control or alter behavior, physical intervention, or mechanical device used to restrict the movement, normal function of a portion of the person's body or control the behavior of a person receiving services. Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are excluded.

Emergency safety intervention means the use of physical restraint or separation as an immediate response to an emergency safety situation. Separation- is not the same as seclusion which is defined as “involuntary confinement or detainment alone in a room or area where the individual is physically prevented from leaving or having contact with others.” Seclusion is prohibited.

Psychotropic Medication means any medication prescribed specifically to treat mental illness and associated symptoms. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, antimania, stimulant, and sedative or hypnotic. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness.

Physical injury means harm, pain, illness, impairment of physical function, or damage to body tissue.

Nebraska state statue mandates the following entities to report: “any physician, psychologist, physician assistant, nurse, nursing assistant, other medical, developmental disability, or mental health professional, law enforcement personnel, caregiver or employee of a caregiver, operator or employee of a sheltered workshop, owner, operator, or employee of any facility licensed by the Department of Health and Human Services Division of Public Health (DPH), or human services professional or paraprofessional not including a member of the clergy.

At a minimum the following incidents must be reported immediately upon provider, participant, or family becoming aware of the incident:

Allegation of abuse or neglect.
Allegation of financial exploitation.
Allegation of sexual exploitation.
Injuries to individuals which require medical attention and treatment by physician.
Injuries to individuals in services related to incidents involving planned or unplanned emergency safety interventions.
Discovery of injury of unknown origin.
Injuries or displacement to individual as a result of fire.
Medication error resulting in injury, serious illness, or hospitalization.
Use of an emergency safety intervention.
Use of physical, chemical, or mechanical restraint for a reason other than an emergency safety intervention.
Deaths of persons served.
Injuries which require medical attention to staff persons and others, resulting from behaviors of individual.
An individual served leaving supervision where the safety of the individual or others is potentially threatened.
Emergency Room, Hospitalization, or use of urgent care facilities for treatment or admission, regardless of type of injury.
Hospital admission due to mental health/behavioral concerns.
Any unplanned hospitalization or ER visit, a transfer to a different hospital, or any unplanned use of urgent care facility.
Law enforcement contacts (i.e. visits to assess or control situations) due to the behavior of an individual served.
Possible criminal activity by individual receiving services or staff person suspected of engaging in criminal activity

towards an individual.
Attempted elopement but staff is present and/or behavior de-escalation occurs before elopement.
PRN psychotropic medication use.
Property damage caused by individual.
Seizure that last over five minutes or over the timeframe set by the individual's physician, or result in treatment at an ER or hospital.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Information concerning protections from abuse, neglect, and exploitation is provided to participants and his/her legal representative by his/her Service Coordinator, as well as in writing in the Non-specialized Services Handbook.

Service Coordination must review and provide a copy of the individual rights and the appeal process at the intake meeting and annually thereafter. As applicable, the participant's rights are translated and provided in their primary language. The Non-specialized Services Handbook includes who to notify and how to notify the appropriate authorities. DHHS has a statewide toll-free number that is available 24/7.

Advocacy groups, such as Nebraska Advocacy Services, People First, and The Arc have provided training on rights, exercising rights, voting, and due process.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incidents are currently required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using the Department approved format, Therap, within 24 hours of the verbal report. A written summary must be submitted via Therap to the Department of the provider's investigation and action taken within 14 days. An aggregate report of incidents must be submitted to the Department on a quarterly basis. Each report must be received by the Department no later than 30 days after the last day of the previous quarter. The reports must include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that result in a reduction in the number of incidents over time.

DDD staff triage the written reports daily and determine the appropriate response which depends upon the type and frequency of the incident. At a minimum the following incidents must be reported:

Allegation of abuse or neglect.
Allegation of financial exploitation.
Allegation of sexual exploitation.
Injuries to individuals which require medical attention and treatment by physician.
Injuries to individuals in services related to incidents involving planned or unplanned emergency safety interventions.
Discovery of injury of unknown origin.
Injuries or displacement to individual as a result of fire.
Medication error resulting in injury, serious illness, or hospitalization.
Use of an emergency safety intervention.
Use of physical, chemical, or mechanical restraint for a reason other than an emergency safety intervention.
Deaths of persons served.
Injuries which require medical attention to staff persons and others, resulting from behaviors of individual.
An individual served leaving supervision where the safety of the individual or others is potentially threatened.
Emergency Room, Hospitalization, or use of urgent care facilities for treatment or admission, regardless of type of injury.
Hospital admission due to mental health/behavioral concerns.
Any unplanned hospitalization or ER visit, a transfer to a different hospital, or any unplanned use of urgent care facility.
Law enforcement contacts (i.e. visits to assess or control situations) due to the behavior of an individual served.
Possible criminal activity by individual receiving services or staff person suspected of engaging in criminal activity towards an individual.
Attempted elopement but staff is present and/or behavior de-escalation occurs before elopement.

PRN psychotropic medication use.
Property damage caused by individual.
Seizure that last over five minutes or over the timeframe set by the individual's physician, or result in treatment at an ER or hospital.

When providers report alleged abuse and neglect of adults that is not required to be reported by law, the Protection and Safety staff share this information with DDD within 24 hours of receipt. DDD staff triages/reviews the information and makes a determination whether to do a complaint investigation or handle it in another manner.

DHHS Protection and Safety staff sends a copy of the intake investigation of reportable allegations of neglect or abuse to DDD when the incident is reported to occur in a DD provider setting.

Timeframes for conducting, completing, and informing the participant of the results of an investigation completed internally by the DD provider are determined by the DD provider agency and are outlined in the DD provider's policies and procedures. Timeframes for state staff are established within the program, following statutory and regulatory mandates when required. Timeframes vary depending upon the involvement of law enforcement, the nature of the critical event, and the legal status of the alleged victim (e.g. State ward).

Each DD provider agency submits an aggregate report of these incidents to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of critical incidents over time.
An aggregate report of these critical incidents is prepared for the DDD QI committee on a quarterly basis. The state QI committee reviews the reports and makes recommendations to the DDD management if necessary.

Investigations of allegations of neglect and abuse are performed by adult protective services (APS) staff in the Division of Children and Family Services. A Priority 1 report of allegation of immediate danger of death or life-threatening or critical harm to a vulnerable adult, including death or other vulnerable adults still at risk have a 60-day time frame in which to complete an investigation. Face-to-face contact must be made with the victim as quickly as possible and within 8 hours. If APS staff cannot make immediate contact with the alleged victim, law enforcement must be contacted to request that they conduct an investigation and send a written summary of their investigation to the APS worker.

A Priority 2 report of an allegation of danger of serious, but not life-threatening or critical, harm to a vulnerable adult have a 45-day time frame in which to complete an investigation. Face-to-face contact by an APS worker or law enforcement must be made with the victim within 5 working days of the receipt of the report into the local office.

Priority 3 reports allege harm to a vulnerable adult which is serious, but not serious enough to be considered Priority 1 or 2 and have a 45-day time frame in which to complete an investigation. Face-to-face contact by an APS worker or law enforcement must be made with the victim within 10 working days of the receipt of the report into the local office.

In accordance with state statutes, upon request or court order, information contained in the registry of adult abuse/neglect is released to the victim or other interested parties. Information to be released and to whom the information can be released is limited by statute and regulations. The victim or legal representative, the reporter of the alleged abuse/neglect, investigating law enforcement, the prosecuting county attorney, the victim's physician, legally responsible agency, defense counsel, the state's designated protection and safety system (i.e. Nebraska Advocacy Services), and state staff responsible for licensing child care programs may be provided information contained on the registry upon request. Upon request, a physician or the person in charge of an institution, facility, or agency making a legally mandated report will receive a written summary of the findings, and actions taken by the Department in response to the legally mandated report.

The State's regulations identify the relevant parties that may request the results of the investigation and these regulations are on the public website. Victims are informed of the release of information contained in the registry upon request at the time of the investigation by the investigator.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Division of Developmental Disabilities within DHHS, the State Medicaid agency, is responsible for overseeing the reporting of and response to critical incidents and events. Incidents are currently required to be verbally reported to

DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using the Department approved format, Therap, within 24 hours of the verbal report. A written summary must be submitted via Therap to the Department of the provider's investigation and action taken within 14 days.

DDD also requires that contracting DD provider agencies implement a system of performance accountability that includes reporting of critical incidents and events affecting the wellbeing of individuals served. An aggregate report of these incidents, prepared by each provider agency, is forwarded to DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of critical incidents over time.

A quarterly report is written and presented to the DD Deputy Director. However, there may be immediate follow-up of individual events.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In Nebraska, restraint means any physical hold, device, or chemical substance that restricts, or is meant to restrict, the movement, normal function of a portion of the person's body or control the behavior of an individual. Seclusion means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. Chemical restraints - drugs, or psychotropic medications used solely for the purpose of modifying behaviors may be used only with the consent of the individual or legal representative. PRN psychotropic medications are prohibited. Devices used to provide support for the achievement of functional body position or proper balance, and devices used for specific medical and surgical (as distinguished from behavioral) treatment are excluded as a restraint.

The use of mechanical restraints, physical restraints, seclusion, and aversive stimuli are not allowable habilitation techniques and are prohibited as a habilitation technique. Physical restraint or separation from harmful circumstances or from individuals at risk can only be used as an emergency safety intervention when the person must be kept form harm (i.e., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the person).

Restrictive methods used should not be employed as punishment, for the convenience of staff, a substitute for habilitation, or be reactive in design. Drugs cannot be used as a way to deal with under-staffing or as a way to deal with ineffective, inappropriate, or other nonfunctional programs or environments. Corporal punishment, verbal abuse, physical abuse, psychological abuse, denial of an adequate diet, and a person in services disciplining another person served, and placing persons in a totally enclosed crib or other barred enclosure are prohibited.

Protocols for the use of physical restraint and separation are written into state regulations and must be included in provider policies, procedures, and practices. An emergency safety intervention which is not used as a behavioral consequence and utilized pursuant to a safety plan is allowed to respond to an emergency safety situation. In instances where the person must be kept from harm, the provider must use their reasonable and best judgment to intervene to keep the person from injuring him/herself or others. This may include the use of separation - hands-on guidance away from harm or to another area or room to safely protect the persons and others from immediate jeopardy or physical harm. An individual could be physically guided away from an area and staff may block the exit. The individual would always have line of sight supervision and the expectation would be that as soon as the risk of harm is no longer present, then they would no longer be kept away from others. The person would not be put in a room, with the door closed and no one watching them.

Behavioral support plans must address behaviors that are obstacles to becoming more independent; that interfere with the ability to take part in habilitation; self -injurious behaviors; or behaviors that are a threat to others. The provider's policies and procedures must specify and define approved intervention procedures, and include a description of the mechanism for monitoring the use. The following components must be in place in a behavioral support plan, a safety plan, and in order to develop emergency safety interventions specific to each individual:
The functional assessments must define the communicative function of the behavior for the person and what purpose the behavior serves in the person's life;
A review of the person's day and residential supports and other relevant data must be incorporated in to the functional assessment process;
A safety plan for the person must be developed that emphasizes positive meaningful activities, individualized supports, and options that are incompatible with the behavior targeted for change;
The plan must include a description of potential stressors and triggers that may lead to the person experiencing a crisis, and then a comprehensive safety program developed and implemented;
The individual's safety plan must include the type of physical restraint and separation, the length of time the emergency intervention will be utilized in each instance, and the monitoring procedures that the staff will perform during each instance; and
There must be meaningful and individualized data collection and data analysis that track progress. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.
Prior written consent of the person or the legal representative must be obtained.

The use of chemical restraints must be prescribed by a physician, be given as prescribed, and each behavioral support plan utilizing chemical restraints must be reviewed and approved before implementation by the team, including the person or their legal guardian, and by the DD provider agency's review committee.

The provider must establish a Review Committee to provide prior review and approval of all behavior support plans, safety plans, and emergency interventions that use chemical restraints to modify behavior, physical restraints, or separation. The effectiveness of the intervention in conjunction with the behavior support plan must be monitored and reviewed. The Review Committee must have persons qualified to evaluate behavior support research and a physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications.

Staff must be informed of potential side effects, in non-technical terms, so that staff can monitor for early detection of side effects. Reports must be made to the physician based on this review.

When a drug is prescribed without prior knowledge and approval of the team or review committee, the drug is administered as prescribed. Development of or revisions to a behavioral support plan and the committee's review and approval must be completed within 30 days.

Medications must be documented in the service plan with the name, dosage, reason for, and the specific behaviors to be affected by the medication; whether the use of the drug was reviewed by the agency's review committee; and whether the drug is reviewed on an ongoing basis by a physician. Medication to manage behavior must be used only in dosages that do not interfere with the person's ability to take part in habilitation and daily living activities. The use of medication is documented after each drug administration.

The service plan must include that a less restrictive and less intrusive method had been tried and systematically applied and determined to be ineffective before use of chemical restraints or emergency safety interventions such as physical restraints or separation for the purpose of modifying behavior. The team must evaluate and document that harmful effects of the behavior clearly outweigh any potential harmful effects of the use of restraints or separation.

Providers must provide orientation of the agency as well as to each person's services. Orientation to each person's services must specifically include the procedures to be implemented, including the use of chemical restraints, physical restraints, or separation for the purpose of modifying behavior, and provided prior to implementation of the procedures. Providers must train staff prior to assuming their duties. Topics include the philosophy, organization, services, practices and goals of the agency, including the use of chemical restraints, physical restraints, or separation for the purpose of modifying behavior; person rights; abuse and neglect; individual program planning, including individualized assessments, base lining, data collection, writing habilitation programs, selecting training materials, and reinforcement types and schedules; medication administration (must be completed prior to administration of drugs); basic first aid; CPR; respite care; recordkeeping; and on-the-job training. Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to persons. This training must include: implementation and development of the service plan and interdisciplinary process; positive support techniques; and approved emergency safety intervention techniques.

DD provider staff that administer drugs must meet the competency standards defined in Title 172, Chapter 95, Regulations Governing the Provision of Medications by Medication Aides and other Unlicensed Persons. The competency standards are listed in Appendix G-3-C-ii.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHHS DDD is responsible for overseeing the use of restraints and ensuring that the state's safeguards are followed.

The methods for detecting the unauthorized use, over use or inappropriate/ineffective use of emergency physical restraints or separation, and behavior modifying drugs and ensuring that all applicable state requirements is performed by state staff and are as follows:
Review of each DD provider's policies and procedures during the provider enrollment process, with recommendations for change as applicable;
On-site certification review activities;
Review of critical incident reports;
Review of reports of events;
DDD Service Coordination monitoring; and
Complaint investigations.

The provider's policies and procedures must be based on state regulations applicable to the use of chemical restraints or emergency safety interventions of physical restraint or separation.

Monitoring of these safeguards is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations. See Appendix G-2-a-i for additional information.

Detection of unauthorized use of restraints may occur at the time of provider enrollment. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of restraints and separation in emergency safety situations. The provider must have an internal quality review system and a Review Committee. When DDD program staff find policies and procedures that do not comply with regulatory requirements, such as unallowable intervention techniques, an insufficient QI system, an inadequate Review Committee, etc., the provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

Detection of unauthorized use of restraints may occur through on-site certification review activities, which may be unannounced or scheduled. During a scheduled certification review conducted by DDD, delivery of service is reviewed as well as the agency's systems. At least 1 person included in the targeted sample must be taking behavior-modifying medication. At a minimum, 33% of the sample includes persons taking behavior modifying medications. The sample is never of only 1 person and always includes at least 3. If additional people pulled in the sample also take behavior modifying drugs, the reviewer will review all pertinent documentation for those people as well. An entire checklist is devoted to review of the development, approval and review of the chemical restraint and how it is incorporated into a training program designed to lessen the need for the restrictive procedure.

Detection of unauthorized use of restraints may occur during unannounced site visits, or walk-throughs. Observations are documented on a checklist. If aggressive behaviors, rights restrictions, or injuries are observed, for example, DDD staff will question provider staff and review individual files, which may reveal unauthorized interventions, inappropriate interventions, or injuries of an unknown nature.

Reporting of incidents is another method to detect unauthorized use of restraints. Providers must report any injuries to persons in services related to incidents involving restraint. Incidents are required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using the Department approved format, Therap, within 24 hours of the verbal report. A written summary must be submitted via Therap to the Department of the provider's investigation and action taken within 14 days. DDD staff triages/reviews the information and makes a determination whether to do a complaint investigation or handle it in another manner.

DDD Service Coordination monitoring may detect unauthorized use of restraints. Monitoring of 100 percent is designed to review the implementation of each person's total service plan after both the annual and semi-annual team meetings. Between these scheduled full monitorings, the SC conducts ongoing unannounced monitoring, which allows for focused monitoring if issues have been raised or are noted during the time of a full monitoring.
Complaint investigations and investigations of allegations of abuse or neglect performed by DHHS staff may also reveal unauthorized, over use, or inappropriate/ineffective use of restraints.

Action that is taken by the State if it is determined through an investigation that unauthorized restraints/inappropriate interventions/unknown injuries are discovered may include an unannounced on-site focused certification review with deficiencies cited followed by a provider plan of correction and follow-up visits. Action may also include requiring the provider to seek training mandated by the State, placing the provider on probation, limiting admissions, or recoupment of payments made to the provider.

Data from the above activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.
Limited data is gathered during the initial provider enrollment activity. The length of time it takes for a provider to be certified, the amount and type of technical assistance that is provided, and the type and location of services to be delivered are data that the DDD central office utilizes to improve the provider enrollment process. When a provider has difficulty developing their policies and procedures related to the use of restraints, certification reviews may be focused on those issues and may have a greater number in the sample of waiver participants who have behavioral support plans.

A summary of certification activities is completed by a DDD Program Specialist and is reviewed semi-annually by the DDD QI Committee (QIC). The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. walk-throughs), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

An aggregate report of the incidents, prepared by each provider agency, is forwarded to the QIC on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of incidents over time. The QIC reviews statewide quarterly reports compiled from the statewide database of

incidents and events, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

To allow for state oversight of the Service Coordination monitoring process, the responses on the forms are entered into a web-based database. This allows for individual SCs to track issues that aren't resolved and provide aggregate information for SC Supervisors, the SC Administrator, and the DDD Central Office. This information is reviewed and acted on, as appropriate, at the local level with reports being provided to the DDD central office staff on a quarterly basis.

A report of complaint investigations is reviewed on a semi-annual basis by the QIC. The report, prepared by DDD includes the number and type of complaint, as well as the disposition of the complaint. Designated DD central office staff review provider quarterly reports

The QIC also reviews semi-annual reports of activities performed by the Death Review Committee.

The frequency of the oversight activities varies by activity.
The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. Walk-through activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data.

Quarterly, the QIC reviews an aggregated report compiled from the statewide database of critical incidents and events.

DDD Service Coordination monitoring reports are provided to the QIC on a quarterly basis. A report of complaint investigations performed by DDD is reviewed on a semi-annual basis by the QIC.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Restrictive interventions, known as emergency safety interventions, that are permitted include an action or procedure that limits an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights. The use of mechanical restraints, physical restraints, seclusion, and aversive stimuli are not allowable habilitation techniques. PRN (as needed) psychotropic medications are prohibited. Chemical restraints, that is, drugs, or psychotropic medications used solely for the purpose of modifying behaviors may be used only with the consent of the individual or legal representative. Physical restraint or separation from harmful circumstances or from individuals at risk can

only be used as an emergency safety intervention when the person must be kept form harm (i.e., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the person).

Protocols for the use of physical restraint and separation are written into state regulations and must be included in provider policies, procedures, and practices. An emergency safety intervention which is not used as a behavioral consequence and utilized pursuant to a safety plan is allowed to respond to an emergency safety situation. In instances where the person must be kept from harm, the provider must use their reasonable and best judgment to intervene to keep the person from injuring him/herself or others. This may include the use of separation - hands-on guidance away from harm or to another area or room to safely protect the persons and others from immediate jeopardy or physical harm. An individual could be physically guided away from an area and staff may block the exit. The individual would always have line of sight supervision and the expectation would be that as soon as the risk of harm is no longer present, then they would no longer be kept away from others. The person would not be put in a room, with the door closed and no one watching them.

The following documentation is required when restrictive interventions are used:
Written agency provider policies and procedures;
Written positive support plan to be used in conjunction with the restrictive measure, the criterion for the elimination of the restrictive measure, and method to collect data;
Written discussion and prior approval by the service plan team and documentation the service plan team's determination of the individual's ability to acquire, retain, or understand the information proposed in the restrictive measure;
Written informed consent;
Incident reports related to the use of restrictive interventions; and
Orientation, training, and/or competency standards for staff prior to implementation of restrictive measures.

All DD agency providers must be in compliance with state regulations that govern the delivery of home and community-based services and licensing standards for centers for individuals with developmental disabilities (DD).

The provider must develop a policy specifying whether they allow for the use of restrictive measures. If the provider allows the use of restrictive measures, the written policies and procedures must include the following:
The restrictive measure determined necessary for one individual must not affect other individuals who receive services in that setting;
The restrictive measure must not be used as punishment, for the convenience of staff, due to shortage of staff, as a substitute for habilitation, or as an effective positive behavior support plan;
The restrictive measure must be the least restrictive and intrusive possible;
All restrictive measures must be temporary;
Prior to proposing a restrictive measure, there must be documented evidence that other less restrictive methods had been regularly applied by trained staff and failed;
The restrictive measure must be safe for the individual; and
Agency-approved restrictive measures must be specified and defined.

Restrictive measures can only be used as an integral part of a written habilitation strategy that is designed to lead to a less restrictive way of addressing the unacceptable behavior and ultimately to the elimination of the behavior for which the restrictive measure is used.

The provider must ensure that the written habilitative strategies stress positive approaches in addressing behaviors. The provider must have written policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each individual.

Methods for detecting the unauthorized use of restrictive measures include provider enrollment, on-site certification reviews, reporting of incidents, service coordination monitoring, and investigation of complaints. See Appendix G-2-a-i for a description of the methods.

Prior to implementation of a restrictive measure, the provider must ensure review and written approval by the service plan team and rights review committee and written informed consent.

The provider must participate in the service plan team process to discuss and review the proposed restrictive measure prior to implementation. The service plan must document the service plan team's determination of the individual's ability to acquire, retain, or understand the information proposed in the restrictive measure.

The discussion and approval of the use of the restrictive measure including the following must be recorded in the individual's service plan:
The proposed restrictive measures;
Methods previously tried and shown to be ineffective;
Risks involved with the restrictive measure and risk involved if no restrictive measure is used;
Rationale for the proposed restrictive measure;
Other possible alternative methods;
Description of the positive support plan proposed to be used in conjunction with the restrictive measure to lead to elimination of the restrictive measure and the criterion for the elimination of the restrictive measure; and
Frequency that the individual's service plan team will review the effectiveness of the plan, but not less than every six months. The service plan team review must address: the original reason for restrictive measure, current circumstances, success or failure of the positive support plan, and the rationale based on evidence for continued use of the restrictive measure; and decrease in the use or elimination of the restrictive measure as soon as circumstances justify, based on established and approved criterion in the service plan.

The provider must obtain written informed consent from each individual or legal representative as applicable, for authorization to use a restrictive measure. The written informed consent must be obtained prior to implementation of the restrictive measure.

In addressing behaviors, the provider must develop and implement policies, procedures, and practices that emphasize positive approaches directed towards maximizing the growth and development of each individual. The provider must ensure the following behavior supports and emergency safety interventions for emergency safety situations:

The provider must assure that the following components of positive behavioral supports are in place:
The assessment must define the communicative function of the behavior for the individual;
The assessment must focus on what purpose the identified behavior serves in the individual's life;
A review of the individual's day supports, residential supports, and other relevant data must be incorporated in the assessment process;
A safety plan for the individual must be developed that emphasizes positive meaningful activities and options that are incompatible with the behavior targeted for change;
There must be a combination of a planned meaningful day and individualized supports for the individual;
The plan must include a description of potential stressors and triggers that may lead to the individual experiencing a crisis. Once identified, there must be a comprehensive safety program developed and implemented; and
There must be meaningful and individualized data collection and data analysis that track the progress of the individual. The data must be presented in a user-friendly manner and collected through a range of methods that are valid and meaningful for planning and evaluation efforts.

The safeguards, practices, protocols, and documentation for the use of restrictive measures are the same as for the use of chemical restraints to modify behaviors, and the use of emergency safety interventions of physical restraint or separation. See G-2-a-i for additional information.

If restrictive, prior written consent of the person or the legal representative must be obtained, except in emergency situations.

Incidents related to the use of restrictive measures must be documented and reported. Incidents are currently required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using the Department approved format, Therap, within 24 hours of the verbal report. A written summary must be submitted via Therap to the Department of the provider's investigation and action taken within 14 days. At a minimum the following incidents related to possible restraint or other restrictive interventions must be reported immediately upon provider, participant, or family becoming aware of the incident:

Allegation of abuse or neglect.
Injuries to individuals which require medical attention and treatment by physician.
Injuries to individuals in services related to incidents involving planned or unplanned emergency safety interventions.
Discovery of injury of unknown origin.
Medication error resulting in injury, serious illness, or hospitalization.
Use of an emergency safety intervention.
Use of physical, chemical, or mechanical restraint for a reason other than an emergency safety intervention.
Deaths of persons served.
Injuries which require medical attention to staff persons and others, resulting from behaviors of individual.
Emergency Room, Hospitalization, or use of urgent care facilities for treatment or admission, regardless of type of injury.
Law enforcement contacts (i.e. visits to assess or control situations) due to the behavior of an individual served.
Possible criminal activity by individual receiving services or staff person suspected of engaging in criminal activity towards an individual.
PRN psychotropic medication use.
Property damage caused by individual.

The provider must ensure that employees (including subcontractors and management) responsible for providing supports and services to individuals with developmental disabilities are educated/trained on the minimum requirements necessary to address the individual's needs prior to working with individuals in services.

Staff responsible for providing direct services must demonstrate the competence to support individuals as part of a required and on-going training program. The provider must ensure staff receive training and demonstrate competencies under the guidance of an already trained and proficient staff member prior to working alone with individuals.

The provider must document in the employee's personnel record that required orientation and training was completed and competency was demonstrated. It is the responsibility of the provider to ensure that training and verification of such is completed by persons with expertise who are qualified by education, training, or experience in those areas.

Initial orientation must be completed by all new employees prior to working alone with individuals. Employees must complete the following training requirements:
Individual's choice;
Individual's rights in accordance with state and federal laws;
Confidentiality;
Dignity and respectful interactions with individuals; and
Abuse, neglect, and exploitation and state law reporting requirements and prevention.

Employees must be trained to respond to injury, illness, and emergencies, and competency verified within 30 days of hire or before working alone with an individual. The following training areas must be addressed:
Emergency procedures;
Cardiopulmonary resuscitation;
Basic first aid;
Infection control;
Individuals' medical protocols as applicable; and
Individuals' safety protocols as applicable.

Employees must be trained and demonstrate competency within 180 days of hire regarding the implementation of the provision of services to individuals. This training must include:
Implementation and development of the service plan and interdisciplinary process;
Positive support techniques;
Approved emergency safety intervention techniques;
Concepts of habilitation, socialization, and age-appropriateness, depending on the needs of the individual;
Use of adaptive and augmentative devices used to support individuals, as necessary;

Other training required by the provider; and
Other training as required by the specific service options.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

DHHS DDD is responsible for monitoring and overseeing the use of restrictive measures.

The State performs methods for detecting the unauthorized use, over use or inappropriate/ineffective use of restrictive measures and ensuring that all applicable state requirements. The State-wide oversight responsibilities listed below employ the same methods described in Appendix G-2-a-i and G-2-b-i.

Only additional information is included in this section regarding:
Review and approval of each DD provider's policies and procedures during the provider enrollment process;
On-site certification review activities;
Review of critical incident reports;
Review of reports of events;
DDD Service Coordination monitoring; and
Complaint investigations.

The provider's policies and procedures must be based on state regulations applicable to the use of restrictive measures.

Monitoring of these safeguards is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations. See Appendix G-2-a-i for additional information.

Data from the above activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.

Limited data is gathered during the initial provider enrollment activity. Information that the DDD central office utilizes to improve the provider enrollment process includes the length of time it takes for a provider to be certified, the amount and type of technical assistance that is provided, and the type and location of services to be delivered. When a provider has difficulty developing their policies and procedures related to the use of restrictive measures, certification reviews may be focused on those issues and may have a greater number in the sample of waiver participants who have behavioral support plans.

A summary of certification activities is completed by DDD and is reviewed semi-annually by the QIC. The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. walk-throughs), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

An aggregate report of the critical incidents and events, prepared by each provider agency, is forwarded to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of incidents over time. The QIC reviews statewide quarterly reports compiled from Therap, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

To allow for state oversight of the SC monitoring process, the responses on the forms are entered into a web-based database. This allows for individual SCs to track issues that aren't resolved and provide aggregate information for SC Supervisors, the SC Administrator, and the DDD Central Office. This information is reviewed and acted on, as appropriate, at the local level with reports being provided to the DDD central office staff on a quarterly basis.

A report of complaint investigations is reviewed on a semi-annual basis by the DDD QI Committee. The report, prepared by DDD includes the number and type of complaint, as well as the disposition of the complaint.

The DD QI committee also reviews semi-annual reports of activities performed by the Death Review Committee.

Currently, Therap reports of incidents are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance.

The QIC reviews statewide quarterly reports compiled from the statewide database of incidents, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.
The frequency of the oversight activities varies by activity.
The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. Walk-through activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data.

Currently each incident is reviewed by DDD staff. Quarterly, the QIC reviews an aggregated report compiled from the statewide database of critical incidents and events.

DDD SC monitoring reports are provided to the QIC on a quarterly basis. A report of complaint investigations performed by DDD is reviewed on a semi-annual basis by the QIC.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving. The use of seclusion as a restrictive measure is not an allowable habilitation technique and is prohibited as a habilitative technique. Separation from harmful circumstances or from individuals at risk can only be used as an emergency safety intervention when the person must be kept form harm (i.e., running into traffic, leaving a moving car or other serious, unusual or life-threatening actions by the person). DHHS DDD is responsible for monitoring and overseeing the use of restrictive measures.

The State performs methods for detecting the unauthorized use, over use or inappropriate/ineffective use of restrictive measures and ensuring that all applicable state requirements. All DD agency providers must be in compliance with state regulations that govern the delivery of home and community-based services and licensing standards for centers for individuals with developmental disabilities (DD).

The State-wide oversight responsibilities are listed below.
Review and approval of each DD provider's policies and procedures during the provider enrollment process;
On-site certification review activities;

Review of critical incident reports;
Review of reports of events;
DDD Service Coordination monitoring; and
Complaint investigations.

The provider's policies and procedures must be based on state regulations applicable to the use of restrictive measures.

Monitoring of these safeguards is undertaken through on-site scheduled and unannounced certification review activities. As during the initial provider enrollment, the provider's policies, procedures, and actual practices must be in compliance with the State's regulations.

Data from the above activities is gathered and analyzed to identify state-wide trends and patterns and support improvement strategies.

Limited data is gathered during the initial provider enrollment activity. The length of time it takes for a provider to be certified, the amount and type of technical assistance that is provided, and the type and location of services to be delivered are data that the DDD central office utilizes to improve the provider enrollment process. When a provider has difficulty developing their policies and procedures related to the use of restrictive measures, certification reviews may be focused on those issues and may have a greater number in the sample of waiver participants who have behavioral support plans.

At a minimum the following incidents related to the possible utilization of separation as an emergency safety intervention must be reported immediately upon provider, participant, or family becoming aware of the incident:

Allegation of abuse or neglect.
Injuries to individuals which require medical attention and treatment by physician.
Injuries to individuals in services related to incidents involving planned or unplanned emergency safety interventions.
Discovery of injury of unknown origin.
Use of an emergency safety intervention.
Use of physical, chemical, or mechanical restraint for a reason other than an emergency safety intervention.
Deaths of persons served.
Injuries which require medical attention to staff persons and others, resulting from behaviors of individual.
Emergency Room, Hospitalization, or use of urgent care facilities for treatment or admission, regardless of type of injury.
Law enforcement contacts (i.e. visits to assess or control situations) due to the behavior of an individual served.
Possible criminal activity by individual receiving services or staff person suspected of engaging in criminal activity towards an individual.
Property damage caused by individual.

A summary of certification activities is completed by a DDD staff and is reviewed semi-annually by the QIC. The certification summary is an aggregate report that includes the number of certifications conducted and the frequency of compliance issues cited by type. Comparison to previous certification reviews of each provider can be made and this information is used to identify trends or patterns and to make recommendations of improvement strategies, such as technical assistance to the provider, additional unannounced site visits (i.e. walk-throughs), or recommendations to DDD service coordination staff for increased, ongoing monitoring of the implementation of the service plan, including delivery of services.

An aggregate report of the critical incidents and events, prepared by each provider agency, is forwarded to the DDD Central Office on a quarterly basis. The reports include a compilation, analysis, and interpretation of data, and include evidentiary examples to evaluate performance that are designed to result in a reduction in the number of incidents over time. The QIC reviews statewide quarterly reports compiled from the statewide database of critical incidents and events, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

To allow for state oversight of the SC monitoring process, the responses on the forms are entered into a web-based database. This allows for individual SCs to track issues that aren't resolved and provide aggregate information for SC Supervisors, management staff, and the DDD Central Office. This information is reviewed and acted on, as

appropriate, at the local level with reports being provided to the DDD central office staff on a quarterly basis.

A report of complaint investigations is reviewed on a semi-annual basis by the QIC. The report, prepared by DDD includes the number and type of complaint, as well as the disposition of the complaint. The QIC also reviews semi-annual reports of activities performed by the Death Review Committee.

The operation of the incident management system is overseen by DDD central office. Electronic reports are reviewed daily to determine if follow-up by DDD central office is warranted, such as a complaint investigation, focused certification review, contract compliance review, or technical assistance. The DDD committee reviews statewide quarterly reports compiled from the statewide database of incidents, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

The frequency of the oversight activities varies by activity. The frequency of on-site certification reviews is based on each provider's current certification standing. Annual or biennial on-site certification reviews are scheduled in advance, but a focused review to address issues found through other oversight activities can occur at any time and may be unannounced. "Walk-through" activities are unannounced. Contract compliance reviews may be announced or unannounced, complaint investigations are unannounced, and both activities are based on the analysis of data.

Quarterly, the QIC reviews an aggregated report compiled from the statewide database of critical incidents and events. DDD SC monitoring reports are provided to the QIC on a quarterly basis. A report of complaint investigations performed by DDD is reviewed on a semi-annual basis by the QIC.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96). Compliance reviews of the provider are completed by the Division of Public Health within DHHS.

First line responsibility for monitoring participant medication regimens resides with the medical professionals that prescribe the medications, every time that the professional prescribes the medications. The medical professional that prescribes the medications determines the frequency of the monitoring, based on the individual's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues.

The monitoring of the appropriateness of each medication and the appropriateness of multiple medications is the responsibility of the medical professionals who prescribe them, the pharmacist who fills the prescriptions, and the provider's review committee.

Each provider must establish a committee to provide prior review of psychotropic medications used solely for the purpose of modifying behaviors, and issues related to research involving clients, for the purpose of ensuring that client rights are not violated. The agency shall have a review committee which includes -
1. Persons qualified to evaluate behavioral research studies/proposals and the technical adequacy of proposed positive behavioral support plans; and

2. A physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications to modify behavior.

First line monitoring methods are carried out by the DD provider, and consist of documenting and reporting the following to the physician at every appointment, legal representative when requested, and the delegating licensed health care professional: Unsafe conditions of medications; adverse reactions to medications; medication errors; and staff observations regarding the behavior which the medication has been prescribed to reduce.

The second line monitors are licensed health care professionals whose scope of practice allows delegation of medication administration. The health care professionals, usually Registered Nurses, delegate the administration of medication to medication aides. The licensed health care professionals are employees of the DD provider agency or who have entered into a contract with the DD provider.

Second line monitoring activities and frequency of monitoring is determined by the health care professional and the DD provider. The medical professional that prescribes the medications determines the frequency of the health professional's monitoring which may be monthly, quarterly, semi-annually, or annually and is based on the individual's specific circumstances in relation to the type of medication, the length of time the medication has been and will be prescribed, any other prescribed medications, height, weight, and other health conditions or issues. The DD provider's monitoring activities may include observation of the administration of medications or treatment; review of records relating to medication provision or treatment; review of incident reports related to medication or treatment errors; retraining, and continued observations.

Staff observations regarding the behavior which the medication has been prescribed to reduce are also reported to the provider's review committee when the positive behavioral supports plan for that individual is scheduled for review. Each DD provider must have policies and procedures that identify the frequency of monitoring.

In addition to meeting statutory and regulatory requirements, the DD provider agencies must have policies and procedures addressing the provision of medications, per applicable state regulations.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement that includes frequency of QA/QI monitoring activities. The provider QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action. The provider's reports of QA/QI activities are reviewed on-site when DDD completes a certification review, annually or every two years, based on the certification status of the provider.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

DHHS Division of Public Health (DPH) is responsible for the oversight of compliance with the Neb. Rev. § 71-6718 - 71-6743, known as the Medication Aide Act. The administration of medication is a regulated activity as a method to ensure that participant medications are managed appropriately. The purpose of the Medication Aide Act is to ensure the health, safety and welfare of individuals through accurate, cost-effective, and safe utilization of medication aides for the administration of medications. Medication aides and other unlicensed persons may help with the physical act and documentation of provision of medication; and, under specific conditions such persons may also assist with monitoring therapeutic effects. Medication aides must be recertified every two years.

The administration of medication by licensed health care professionals is regulated by their respective practice acts. Under these regulations, administration of medication in the home is regulated only if provided through a licensed home health agency or through certified home and community-based providers. These regulations do not govern self-administration of medication. These regulations do not govern the provision of medication in an emergency situation. Licensed home health agencies do not administer medications to waiver participants that receive provided operated waiver services. This section only applies to medications administered by certified DD agency providers.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:
a. Review of each DD provider's policies and procedures during the provider initial certification process;
b. On-site certification review activities; and
c. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDD staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled are oversight activities completed by DDD. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of individuals served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including persons prescribed behavior modifying medication. The sample size ranges based on the number of individuals served at the site; however, it is never of only 1 person and always includes at least 3. From this certification review, it would be determined whether or not individuals receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff cites deficient practice and the provider agency must submit a formal Plan of Improvement (POI) addressing citations. The POI must be approved by DDD, and the provider is advised of changes that may be necessary to the POI.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH approves Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A. These competencies include:
1. Maintaining confidentiality;
2. Complying with a recipient's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five Rights (Provides the right medication, to the right person, at the

right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property;

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and his/her status on the Medication Aide Registry is ACTIVE.

Data for medication errors consists of individual performance errors and cannot be used to identify trends and patterns. The quality assurance strategy consists of removing the medication aide from the registry.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. On an ongoing basis, when a complaint involving the performance of a Medication Aide is received by the DPH by phone, FAX or on-line, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry. The risk of continued harmful practices is eliminated by removing the medication aide from the registry.

DDD service coordination monitors the implementation of the service plan, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual service plan and semi-annual service plan. This full review is completed for each waiver participant at a minimum of twice annually.

Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DD provider agencies have ongoing responsibility to ensure medications administered by the provider are monitored and are being provided in accordance with applicable state statutes and regulations (§ 71-6718 - 71-6743, 28-372, and 28-711; 172 NAC chapters 95 and 96).

The purpose of the Medication Aide Act is to ensure the health, safety and welfare of individuals through accurate, cost-effective, and safe utilization of medication aides for the administration of medications.

Medication aides are persons that are unlicensed and provide medication administration only under the direction and monitoring of: 1) a licensed health care professional whose scope of practice allows medication administration; 2) a recipient with capability and capacity to make informed decision about medications for his/her medication (i.e. self-administration); or 3) a caretaker. Caretaker means a parent, foster parent, family member, friend, or legal guardian who provides care for an individual. A caretaker provides direction and monitoring and has capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

A caretaker has current first-hand knowledge of the recipient's health status and the medications being provided, and has consistent frequent interaction with the recipient. A staff member of a facility, school, or other entity is not a caretaker.

The ability to self-administer medication means that the individual is physically capable of:

a. The act of taking or applying a dose of a medication;

b. Taking or applying the medication according to a specific prescription or recommended protocol;

c. Observing and monitoring him/herself for desired effect, side effects, interactions, and contraindications of the medication, and taking appropriate actions based upon those observations;

d. Receiving no assistance in any way from another person for any activity related to medication administration.

The inability to self-administer medications means the individual:

a. Is not at least 19 years of age. Minor children may take their own medication(s) with appropriate caretaker monitoring;

b. Does not have cognitive capacity to make informed decision about taking medications;

c. Is not physically able to take or apply a dose of a medication;

d. Does not have capability and capacity to take or apply a dose of medication according to specific directions for prescribed medications or according to a recommended protocol for nonprescription medication; and

e. Does not have capability and capacity to observe and take appropriate action regarding any desired effects, side effects, interactions, and contraindications associated with a dose of medication.

The DD provider agency must evaluate an individual's medication administration abilities, and determine the level of assistance needed for medication administration.

For recipients who do not have the capability and capacity to make informed decision about medications and for whom there are not caretakers, acceptance of responsibility for direction and monitoring must be provided by a licensed health care professional.

Documentation may be accomplished by any of the following methods:
(1) When licensed health care professionals are employees, entities may identify on an individual basis or by title and job description/role delineation the licensed health care professional or the classification(s) of licensed health care professionals who are responsible to provide direction and monitoring. Written acceptance of responsibility is not required to be recipient specific and can be through acceptance of title and job description/role delineation.

(2) When licensed health care professionals are not employees, entities must identify the licensed health care professional by name, profession, and license number who is designated to provide direction and monitoring. Written acceptance of responsibility needs to be recipient specific.

(3) A licensed health care professional who provides services directly to a recipient for direction and

monitoring, rather than indirectly through facility employment, needs to have a written contract with the recipient or other responsible party on behalf of the recipient which identifies acceptance of said responsibility.

The minimum competency standards are defined in regulations. Medication aides and other unlicensed persons who provide medication must:

(1) Recognize the recipient's right to personal privacy regarding health status, any diagnosis of illness, medication therapy and items of a similar nature. Information of this nature should only be shared with appropriate interdisciplinary team members.

(2) Recognize and honor the right of those recipients, with capability and capacity to make an informed decision about medications, to refuse medications and at no time to be forced to take medications. In the case of a recipient who does not have the capability and capacity to make informed decision about medications, recognize the requirement to seek advice and consultation from the caretaker or the licensed health care professional providing direction and monitoring regarding the procedures and persuasive methods to be used to encourage compliance with medication provision. Recognize that persuasive methods should not include anything that causes injury to the recipient.

(3) Follow currently acceptable standards in hygiene and infection control including hand washing.

(4) Follow facility policies and procedures regarding storage and handling of medication, medication expiration date, disposal of medication and similar policies and procedures implemented in the facility to safeguard medication provision to recipients.

(5) Recognize general unsafe conditions indicating that the medication should not be provided including change in consistency or color of the medication, unlabeled medication or illegible medication label, and those medications that have expired. Recognize that the unsafe condition(s) should be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(6) Accurately document medication name, dose, route, and time administered, or refusal.

(7) Provide the right medication, to the right person, at the right time, in the right dose, and by the right route.

(8) Provide medications according to the specialty needs of recipient's based upon such things as age, swallowing ability, and ability to cooperate.

(9) Recognize general conditions, which may indicate an adverse reaction to medication such as rashes/hives, and recognize general changes in recipient condition, which may indicate inability to receive medications. Examples include altered state of consciousness, inability to swallow medications, vomiting, inability to cooperate with receiving medications and other similar conditions. Recognize that all such conditions shall be reported to the caretaker or licensed health care professional responsible for providing direction and monitoring.

(10) Safely provide medications for all ages of recipients according to the following routes: oral, topical, inhalation and instillation as referenced in section 005.

(11) Recognize the limits and conditions by which a medication aide or other unlicensed person may provide medications.

(12) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a vulnerable adult has been subjected to abuse or conditions or circumstances which would result in abuse in accordance with Neb. Rev. Stat. 28-372.

(13) Recognize the responsibility to report and the mechanisms for communicating such to the appropriate authorities if reasonable cause exists to believe that a child has been subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which reasonably would result in abuse or neglect in accordance with Neb. Rev. Stat. 28-711.

(14) Recognize the recipient's property rights and physical boundaries.

The regulations relating to medication aides specify that direction and monitoring of the medication

administration completed by medication aides will be completed on an ongoing basis. The DD provider agency must have policies and procedures in place for monitoring medication administration by medication aides.

State Statute 71-1132.01 to 71-1132.53, the Nurse Practice Act also applies. The Nurse Practice Act specifies that practice of nursing by a registered nurse means assuming responsibility and accountability for nursing actions which include delegating, directing, or assigning nursing interventions that may be performed by others, and do not conflict with the Act.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Medication errors must be reported to the person responsible for providing directions and monitoring. This person could be a recipient with capability and capacity to make informed decision about medications for his/her medication (i.e. self-administration), a caretaker, or a licensed health care professional.

Medication errors suspected to be abuse or neglect must be reported to DHHS Protection and Safety Services or law enforcement.

Medication errors are any violation of the "five Rights" - providing the right medication, to the right person, at the right time, in the right dose, and by the right route, or inaccurate documentation of medication name, dose, route, and/or time administered.

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Each DD provider agency must have policies and procedures for internal quality assurance and quality improvement. The provider's QA/QI activities include reviewing medication errors to identify potentially harmful practices, and follow-up to prevent errors in the administration of medications, such as retraining med aides or disciplinary action.

Ensuring that all applicable state requirements are met is performed by state staff. DDD completes the following oversight activities regarding the administration of behavior modifying medications:
a. Review and approval of each DD provider's policies and procedures during the provider initial certification process;
b. On-site certification review activities; and
c. DDD Service Coordination monitoring.

The provider's policies and procedures must be based on the regulations applicable to the use of behavior modifying drugs. One component of the enrollment process consists of a review of the provider's policies and procedures for compliance with state regulations. The provider agency is required to develop policies and procedures that govern the use of behavior modifying medications. The provider must have an internal quality review system and a Review Committee. When DDS program staff find policies and procedures that do not comply with regulatory requirements, such as an insufficient QI system, an inadequate Review Committee, etc., the prospective provider is contacted for additional information or correction of policies and procedures. The provider must make revisions and resubmit to DDD.

On-site certification review visits, which may be unannounced or scheduled are oversight activities completed by DDD. During a certification review, service delivery is reviewed among other aspects of agency systems. A sample of individuals served by the provider agency are selected for review during the certification visit, with a minimum of 33% of the sample including persons prescribed behavior modifying medication. The sample size ranges based on the number of individuals served at the site; however, it is never of only 1 person and always includes at least 3. From this certification review, it would be determined whether or not individuals receiving medication from medication aides in accordance with physician' orders. When this evaluation identifies any potentially harmful practices, the DD provider's follow-up /change of these practices is reviewed. State staff cites deficient practice and the provider agency must submit a formal Plan of Improvement (POI) addressing citations. The POI must be approved by DDD, and the provider is advised of changes that may be necessary to the POI.

DHHS-DPH staff is responsible for monitoring the performance of medication aides employed by the certified agency providers on an ongoing basis. Upon request by DPH, an evaluation of the Medication Aide's medication administration records is reviewed for continued compliance with the state statute. When the DPH discovers that a medication aide is not in compliance with the State statute, the medication aide is removed from the registry.

On an ongoing basis, DPH oversees the regulatory requirements for certification of medication aides by maintaining the Medication Aide Registry. The training requirements for medication aides are outlined in 172 NAC 96-004.02 and DPH approves Medication Aide examinations and procedures. Medication aides must successfully complete a 40-hour course. The course must be on the competency standards identified in 172 NAC 96-005.01A.
These competencies include:
1. Maintaining confidentiality;
2. Complying with a recipient's right to refuse to take medication;
3. Maintaining hygiene and current accepted standards for infection control;
4. Documenting accurately and completely;
5. Providing medications according to the five rights (Provides the right medication, to the right person, at the right time, in the right dose, and by the right route);
6. Having the ability to understand and follow instructions;
7. Practicing safety in application of medication procedures;
8. Complying with limitations and conditions under which a medication aide or medication staff may provide medications;
9. Having knowledge of abuse and neglect reporting requirements; and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Upon successful completion of the certified Medication Aide course, the applicant must pass a competency test in order to be placed on the Medication Aide registry. All medication aide registrations expire two years after the date of registration and the applicant must renew their registration. Failing to renew their registration by the expiration date will automatically result in a registration status changed to EXPIRED and the medication aide will not be eligible to provide medications until formal registration is complete and his/her status on the Medication Aide Registry is ACTIVE.

Data for medication errors consists of individual performance errors and cannot be used to identify trends and patterns. The quality assurance strategy consists of removing the medication aide from the registry.

DDD service coordination monitors the implementation of the service plan, which would include medication administration when applicable. At a minimum, monitoring of the management and administration of behavior modifying drugs is completed twice annually by the participant's DDD service coordinator, as part of the full

monitoring. A full monitoring is a total review - completing a monitoring tool with 42 indicators of compliance within 60 days of implementation of each participant's annual service plan and semi-annual service plan. This full review is completed for each waiver participant at a minimum of twice annually.
Although DDD service coordination would not cite deficient practice statements regarding the provision of medications, the service coordinator would ensure that appropriate provider agency staff was informed.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of reported incidents, the number of incidents that were filed within 24 business hours of becoming aware of the incident, in accordance with the State reporting guidelines.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reports - SharePoint, Therap

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually, or as determined by the DD QI Committee and/or Deputy Director

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of behavioral incidents investigated, the number of citations issued as a result of the investigation.

Data Source (Select one):

Other
If 'Other' is selected, specify:
DD Surveyor/Consultant complaint investigation activities – SharePoint, Therap THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	semi-annually, or as determined by the DD QI Committee and/or Deputy Director

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of incidents reported, the number and percentage of restraints that were reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reports - SharePoint, Therap. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually, or as determined by the DD QI Committee and/or Deputy Director

Performance Measure:
Of the total number of incidents reported, the number of reports of the use of seclusion reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reports - SharePoint, Therap. THIS IS ONE DATA SOURCE.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☑ **Continuously and Ongoing**	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually, or as determined by the DD QI Committee and/or Deputy Director

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of service coordination monitorings, the number of monitorings that indicate all annual medical evaluations are completed as needed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SC Supervisor service plan review – SharePoint, Therap and InfoPath

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: following each annual and semi-annual service plan team meetings	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DD Waiver Eligibility Determination worksheet – SharePoint, Therap and InfoPath

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: with each initial and annual waiver eligibility determination	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: or as determined by the DD QI Committee and/or Deputy Director

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Nebraska state statute 83-1202 states that it is the intent of the Legislature that the first priority of the state in responding to the needs of persons with developmental disabilities should be to ensure that all such persons have sufficient food, housing, clothing, medical care, protections from abuse or neglect, and protection from harm. Inherent throughout the State regulations, providers of waiver services and supports must ensure that individuals are free from abuse, neglect, mistreatment, and exploitation; health, safety, and well-being of the individual is a priority; and individuals are treated with consideration, respect, and dignity. State statute 83-1216 and state regulations also require that all DD providers who will provide direct contact services undergo background checks. DHHS also adhere to state statute by completing background and criminal history checks prior to hiring DDD service coordinators.

Information concerning protections from abuse, neglect, mistreatment, and exploitation is provided to participants and his/her legal representative prior to the initiation of services and annually thereafter. Waiver participants may contact DHHS Protective Services or law enforcement. Waiver participants may also tell their DDD SC, a trusted friend or family member who will report the suspected abuse or neglect on the participant's behalf. DHHS has a statewide toll-free number for reporting allegations which is available 24/7.

Incidents are required to be verbally reported to DDD staff immediately upon the provider becoming aware of the suspected abuse and neglect and reported in writing using the Department approved format, Therap, within 24 hours of the verbal report. A written summary must be submitted via Therap to the Department of the

provider's investigation and action taken within 14 days. DDD staff triages/reviews the information daily and makes a determination whether to do a complaint investigation or handle it in another manner.

Since 1992, Nebraska has had a Death Review Committee to review all deaths of persons served by DD habilitative providers. The Death Review Committee membership includes representatives from DHHS DDD, the Division of PH, Adult Protective Services, and staff from the Medicaid program.

Nebraska's Death Review Committee reviews information submitted by specialized providers of service relative to the death of persons whose services are funded by the State of Nebraska. This is done in an effort to determine trends or individual situations which may indicate training and/or education needs and to provide information to service providers regarding best practices and prevention. The Death Review Committee has expanded their review of deaths of persons to include persons whose services are provided by community supports providers.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The State has set up processes to address individual problems as they are discovered.

DHHS staff conducts reviews of each service plan and additional evidence of the process to ensure the service plan reflects the individual's directions, preferences, and personal and career goals, the service plan is based on adequate assessments of their abilities, and that health and safety issues are addressed. When variances are noted, the SC and their Supervisor are notified and take action to correct the service plan. If issues are discovered that will affect the waiver status of the individual, the SC is notified and given a date to respond. The date of response is determined by the Disability Services Specialist (DSS) and varies between 5 working days and 10 working days, based on the nature of the issue. Failure to receive corrections will result in the removal of the person from the waiver and notification of the SC supervisor. Correction of the areas of concern may allow the person to be maintained on the waiver or to be put back on the waiver, if they had lost their waiver status. There is no gap in services to the participant; services are funded by state general funds to ensure continuation of services, health and safety. Other issues that do not effect waiver funding are passed along to the Supervisor of the SC responsible for the development of the service plan.

DDD Service Coordination monitors the implementation of the service plan to ensure the timely and efficacious delivery of all services specified in the service plan for the person. Full reviews are conducted within 60 days of the annual and semi-annual service plans. Partial reviews are conducted on an ongoing basis, as a part of the ongoing monitoring process or in response to concerns brought up by the consumer, their family or others. The full reviews consist of checking on items grouped into six groupings: rights, habilitation, financial, service needs, health and safety, and home/work environment.

When issues or problems are discovered during a SC monitoring, the individual's SC documents on the monitoring form a plan to address the issues identified. The plan to address issues may include a team meeting, the facilitation of sharing information between the individual, manager of services, and/or providers, etc. A timeline to address the issues and/or a service plan team meeting date is noted on the monitoring form as well as whether the issues were resolved within the timeline.

A review of the service plan and the on-site monitoring are documented and entered into a database. This allows individual SCs to track issues that aren't resolved and for DSSs and SC Supervisors to have access to the information in aggregate form to look at the performance of individual service coordinators, and provide aggregate information for SC Supervisors, the Service Coordination Administrator, and the DDD central office. This information is reviewed and acted on, as appropriate, at the local level.

This information is summarized and reviewed by the DDD QIC quarterly. The summarized data for the service plan review is also shared with service coordination staff at the local level and the DSSs. The implementation data summary is shared with Service Coordination, providers and DDD Central Office staff.

By statute, providers have to report any suspected incidents of abuse/neglect to DHHS Protection and Safety Specialists. When providers report alleged abuse and neglect of adults that is not required to be reported by law, the Protection and Safety staff share this information with DDD within 24 hours of receipt. DDD staff

triages/reviews the information and makes a determination whether to do a complaint investigation or handle it in another manner.

A database for incidents is Therap and the database allows DDD to review and aggregate data in various formats. Quarterly, providers submit a report to DDD detailing the incidents in the quarter and actions taken both on an individual and provider wide level to address the issue and to decrease the likelihood of future incidents. A summary of all the incidents and of the providers efforts are compiled into a report reviewed quarterly by the QIC.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-annually or as determined by the DDD QI committee or DDD Deputy Director

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Nebraska Department of Health and Human Services (DHHS) is the Single State Medicaid Agency. The State Medicaid Director is in the Division of Medicaid and Long Term Care Services. The State Medicaid Director has the ultimate authority for all of Nebraska's Medicaid services.

The quality improvement strategy for Nebraska covers all services funded by the DHHS-DDD, including the services offered under the HCBS waivers for adults (0394, 0396) and children (4154) with developmental disabilities as well as services funded by state general funds only. Nebraska's QI strategies include stratifying information for each respective waiver.

The Nebraska DDD QI system initiates self-auditing and self-correcting processes to assure the sustainability of regulatory compliance, and the flexibility to pursue excellence in service to people with developmental disabilities. The performance measures of the Home and Community-Based Services (HCBS) waivers provide a quality framework that focuses on participant-centered desired outcomes addressed through discovery, remediation, and continuous improvement. In addition, requirements and recommendations associated with the DOJ Agreement with Nebraska contribute to this plan.

DHHS DDD, within the single State Medicaid agency, operates the Home and Community Based Services

(HCBS) waivers for adults and children with developmental disabilities. DHHS staff enroll independent providers to deliver participant-directed non-specialized services to eligible individuals. DHHS DDD formally certifies DD community based provider agencies and DDD contracts with certified DD provider agencies, to deliver specialized habilitation services. The Division has a formalized review process conducted by designated DDD staff to determine eligibility of individuals for the waivers. An individual's eligibility for waiver services is established on an initial and annual basis.

The Division's quality assurance efforts include a Continual Quality Improvement (CQI) system to effectively monitor community-based placements and programs with appropriate protections, services, and supports. This is partially accomplished through active monitoring for individuals in services through local Service Coordination offices.

In order to assure protections, services, and supports on a systems level, the Division has established a formal certification and review process in accordance with state regulations, contract specifications, and state waiver requirements for provider agencies providing specialized services. This certification process includes certification and service reviews of community-based providers and programs by DDD Surveyor/Consultants, who are scheduled to visit providers in accordance with the initial provisional, 1-year, or 2-year certifications issued by the Division. The purpose of the reviews is to identify gaps and weaknesses, as well as strengths, in specialized services provided on a statewide level. In order to ensure continued certification as a provider of DD specialized services, a formal plan of improvement is required to ensure remediation of review findings that need to be addressed. On an ongoing basis, incidents and complaints associated with certified providers which have been reported to the Division are reviewed and appropriate levels of follow-up are conducted.

DDD offers a variety of services and supports intended to allow individuals with DD to maximize their independence as they live, work, socialize, and participate to the fullest extent possible in their communities. A combination of non-specialized and specialized services are offered under the waivers for adults, and children and their families as appropriate, to allow choice and flexibility for individuals to purchase the services and supports that only that person may need or prefer. Non-specialized services to provide support in community living are services directed by the individual or family/advocate and delivered primarily by independent providers. These self-directed, or participant-directed, services are intended to give the individual more control over the type of services received as well as control of the providers of those services. Specialized services are habilitation services that provide residential and day habilitative training and are delivered by contracted certified DD community-based agency providers.

The DHHS DDD Quality Improvement efforts for Community Based Services are coordinated through the DDD QI Committee (QIC) comprised of representatives from DDD Central Office, DHHS Medicaid, and DDD Service Coordination. The DHHS Licensure Unit provides aggregate data as requested. The QIC meets quarterly and reviews aggregate data for statewide monitoring, incidents, complaints, investigations, and certification and review surveys, to identify trends and consider statewide changes that will support service improvement. The Committee also reviews data and reports on subjects, including, but not limited to:
• HCBS waiver service requirements
• Licensure Unit investigations
• Quality Review Team activities, and
• Service utilization information.

The continuing efforts are to oversee and refine the formal design and implementation of QI systems that allow for systematic oversight of services across the state by the QIC, while ensuring utility of the information at the local level. A regular reporting schedule has been developed to ensure regular review of the results of the various QI functions. The minutes show review of results and recommendations for remediation, both to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

The QIC receives reports and information and provides/shares feedback and support to the service districts. The MLTC representative verbally reports activities of the QIC to his/her administrator and/or the Medicaid Director and makes all meeting minutes and reports available for his review.

The QIC minutes show review of results, recommendations for remediation, and follow-up of recommendations or assigned tasks to address issues that have been identified and to proactively decrease the likelihood of similar problems occurring in the future.

A continuous evaluation component is built into the system for evaluation of utility, information received, and effectiveness of strategies.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☑ **Other** Specify: semi-annually, or as determined by the state DDD QI committee or DDD Deputy Director

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Program/Service Delivery Effectiveness:
Effectiveness is measured through dimensions of service quality including accessibility, availability, efficiency, accuracy, continuity, safety, timeliness, respectfulness, and other dimensions as appropriate.

DD Division QI operational framework and procedures are as follows:

A. PDSA for testing changes to the QI Data Collection Process:

1. Plan
What is Being Measured?
Why is it Being Measured?
What is the Data Source?
Who is Responsible?

2. Do
What Will Be Done and
How Frequently Will It Be Done?
How Will Data Be Collected
Who Will Collect the Data?
How/Who Will Aggregate the Data and Generate Reports?
In What Format Will Data Be Reported?

3. Study
Who/When Will Results be Reviewed and Interpreted?
To Whom Will Recommendations be Made/Timeframes?

4. Act
Who Will Implement/Over-See Recommended Changes?

B. Reporting Data

1. Process of Aggregating Data and Monitoring Data Trends

Data are aggregated through queries from systems where data are entered directly by the worker or reporter. These systems include
• Info Path,
• SAS,
• N-FOCUS,
• Therap,
• SharePoint, and
• OnBase.

For data that are not entered directly into a system, data are derived from individual source documents such as audits of files or certification reports and manually tabulated as necessary.

2. Report Formats
Reports reflect information via graphs, tables, and narratives. QIC minutes display meeting topics and discussion, as well as action plans or follow-up categorized by performance measures.

C. Communicating Results
Aggregate data are shared through the QIC with DD Administrative staff, Service Coordination, and other stakeholders. Data reports are submitted as requested to CMS representatives and the Department of Justice Independent Expert.

D. Using Data for Implementing Improvement
Data are reviewed on at least a quarterly basis through the QIC and DD Administration. Appropriate recommendations, action plans, and follow-up are included within the QIC minutes.

E. Assessment of the Effectiveness of the QI Process
Contributors to the assessment of the QI process can be determined through CMS audit and onsite visit reports and findings. In addition, effectiveness is also measured through the relevancy that collected data have in providing useful information on the timeliness and quality of services provided through Community Based services.

The DDD central office management team is responsible for coordinating the monitoring and analysis of system design changes. The management team works in conjunction with the QIC and the program staff to develop methods of evaluation when implementing system design changes. The goal is to clearly define the outcome desired as a function of the system change and to allow the gathering of data and other information related to the state of affairs prior to the system change.

In cases where this is not reasonably possible, efforts are made to develop alternate strategies to capture information post hoc that will allow a determination of whether the outcome was met. In those cases, it is more difficult to attribute the outcome measurement directly to the systems changes than when adequate baseline measures can be compared to measures taken following the system change.

An example of the development and monitoring of systems changes strategies can be provided. An example of a system change was the decision to utilize Therap, a web-based application for reporting incidents. Prior to the implementation of reporting via Therap, incident reporting and follow-up was manually logged in by DDD staff. Incidents are verbally reported to DDD staff immediately upon the provider becoming aware and reported in writing using Therap within 24 hours of the verbal report. A written summary must be submitted via Therap to the Department of the provider's investigation and action taken within 14 days. DDD staff triage the written reports daily and determine the appropriate response which depends upon the type and frequency of the incident. When an incident needs investigating, the incident is entered into SharePoint, a Microsoft product, and another example of system change. Sharepoint allows DDD staff to document the investigation and disposition of each complaint. The use of Therap and SharePoint has improved the methods of data collection and aggregation. The QIC reviews statewide quarterly reports compiled from Therap, which identify the types and numbers of incidents by provider within a geographical area, and identify areas of concern and improvement, and make recommendations for follow-up. A summary of each provider's quarterly report is also included in the statewide report.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement strategy for Nebraska covers all services funded by the DHHS-DDD, including the services offered under the HCBS waivers for adults (0394, 0396) and children (4154) with developmental disabilities as well as services funded by state general funds only. Nebraska's QI strategies include stratifying information for each respective waiver.

Contributors to the assessment of the QI process can be determined through CMS audit and onsite visit reports and findings. In addition, effectiveness is also measured through the relevancy that collected data has in providing useful information on the timeliness and quality of services provided through Community Based Services.

The Quality Improvement Strategy is evaluated on various levels in a relatively systematic basis. Information reviewed by the QI committee is scrutinized to assess the reliability and thus, validity of the information being presented each time a committee meeting is held.

A web-based reporting and tracking method for critical events or incidents, Therap, was implemented in April 2011 to allow for coordinated responses, more frequent analysis of the data, and coordinated efforts for remediation activities and follow-up. DDD also utilizes the Document Library in SharePoint, an intranet application of the Microsoft Outlook software, to store current forms, policies, and procedures. InfoPath forms, another Microsoft Outlook product, are utilized for complaint investigations as well as HCBS waiver LOC determinations. The Document Libraries allow access and utilization by all DDD staff - disability services specialists, service coordination, surveyor/consultants, administrators, and QI staff.

All metadata is organized to allow for stratification by each perspective waiver. This will allow the DDD administration to access the information as needed in a more efficacious manner.

There is also a self-correcting nature based on strategies used to affect systems change. As the QIS becomes more mature, the development of remediation strategies becomes influenced by the history of prior efforts. The historical access to and cooperation with various levels of personnel and resources as well as the efficacy of historical strategies all influence the development of new remediation strategies. The QI strategies are evaluated at a minimum once during the waiver period and prior to renewal.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Financial accountability, or integrity, is a joint responsibility of the Division of Developmental Disabilities (DDD) with assistance from the DHHS Operations.

DDD is responsible to ensure the integrity of the day-to-day authorization and claims processes. DDD staff authorizes services, verify individual claims, correct suspended claims, and track the participant’s utilization of waiver services. DDD staff may conduct financial reviews of provider claims when concern is raised through monitoring, certification activities, or complaint investigations.

Financial Services within Operations tracks audit reports, operates the cost allocation plan, prepares and monitors budget projections for the Division of Medicaid and Long-Term Care and the Division of Developmental Disabilities, prepare federal and state reports as required, and prepare the CMS-64 and 372 reports.

(a) Requirements concerning the independent audit of provider agencies.
DD agency providers are required by contract to do an annual audit of their operations. These are submitted to Financial Services and are reviewed by an analyst for any audit findings or exceptions that might impact on State payments by or for the provider.

Services that are delivered by independent individual providers rather than provider agencies do not require an

independent audit. Independent individual providers are required to retain financial and statistical records to support and document all claims.

(b) The financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits.

DDD utilizes Therap as the electronic waiver services budget authorization and provider claims system. A claim is created in Therap by the provider, DDD staff review and approve the claim, and the claim is electronically submitted to NFOCUS, the state's electronic payment system.

DDD staff and the Therap system do a pre-audit of all provider claims to assure the accuracy of coding and billing.

Independent non-specialized providers must document, using an approved format, the type of service provided, the times each service was provided, and the dates the service(s) were provided to each individual. This record of service is submitted to the individual, along with the billing, or claim for services. The individual, legal guardian or representative verifies the accuracy of the claim by reviewing and signing the record of service. The record of service and provider claim are then submitted to DHHS staff.

DD provider agencies submit electronic claims to DHHS staff without supporting documentation. However, supporting documentation, including staff timecards, individual attendance records or activity schedules, program data records, or other documentation as determined by the Division must be available to Division staff upon request. The agency must maintain records and documentation in sufficient detail, such as staff timesheets and location of service provision, to allow state staff to verify units of service provided to individuals as certified on the electronic billing document.

Prior to submitting the claim for payment, local DHHS staff are responsible to review and verify the units of services billed by the providers. DHHS staff may provide assistance to providers regarding on-line Therap billing processes and proper codes for billing. As a part of the efforts to ensure accurate billing, Suspended DD Claims Reports are generated for billings that do not match the authorizations for service. DDD Central Office staff review these claims and make adjustments to ensure accurate billing.

Individual audits of provider claims may be conducted in response to concerns raised by complaints or certification or licensure reviews. DD central office staff will review documentation to support the claim for services. This documentation may include, but is not limited to, the provider record of service and corresponding claim, agency staff time sheets and corresponding claims, service authorizations, service coordination tracking of the utilization of services, and the service plan. When issues are found that may be considered fraudulent claims; those issues are referred to the DHHS Medicaid Program Integrity unit, or the Medicaid Fraud Control Unit of the Nebraska Department of Justice Office of the Attorney General.

DDD also conducts internal quality assurance activities related to the use of funding. Billing and authorization data is queried to track trends in costs and service use by area, provider and statewide.

Financial Services track the use of Medicaid funding and provide monthly updates on the use of waiver funding relative to the budgeted amounts. This aids DDD in determining the efficacy of efforts to enhance our monitoring and oversight of the use of waiver funding.

(c) The agency (or agencies) responsible for conducting the financial audit program.
The State of Nebraska has a statewide single audit of DHHS conducted on an annual basis. The Auditor of Public Accounts, an independent State agency, conducts this independent single audit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read*

"State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of paid waiver claims, the number of waiver claims that were paid in accordance with the authorization.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SharePoint, Therap

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: or as determined by the DD QI Committee and/or Deputy Director

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Of the total number of audits conducted annually, the number of audits that indicated the rates for waiver services were set in accordance to the approved rate methodology.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SharePoint, Therap

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: per occurrence, or as determined by the DD QI Committee and/or Deputy Director	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the DD QI Committee and/or Deputy Director

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Financial accountability is a joint responsibility of DDD with assistance from Financial Services staff within DHHS Operations.

The following controls are currently employed to ensure payments are made only for services rendered:
1. The need for the service is documented in the service plan.
2. DHHS staff have enrolled, certified, and/or contracted with the waiver provider and prior-authorized each waiver service to be delivered.
3. When services are delivered by an independent provider, a calendar is completed, listing the date of service

(s), the specific task(s), and the times of service, and signed by the waiver participant or designee, verifying the services have been delivered as claimed. The calendar and claim are submitted for approval.
5. DHHS staff review the claim and submit claim to DHHS claims processing staff for processing.
6. Edits are in place in the computer system.

A pre-audit of all specialized provider agency claims is completed to assure the accuracy of coding and claim. Prior to submitting claims to Financial Services for processing, DDD Service Coordination is responsible to review the units of services billed by the providers.

Therap, DDD's current electronic system for authorization and claims processing, was designed to meet the CMS requirements and the HCBS waiver specifications. The system also completes a pre-audit of all claims as a part of the efforts to ensure accurate claims. A claim must include: The provider that provided the service, the person who received the service, the service authorization identification number, the service type, the dates of service, the frequency and rate authorized for the service, the actual number of units provided for the stated time period and the total amount claimed. When a claim is submitted and entered into NFOCUS, the system validates all submitted information against the service authorization on file. Edits are built into NFOCUS to audit the service authorization time period, the claim time period, the number of remaining authorized units, and math computations. Claims that fail to pass validation or auditing are suspended from processing for review by DDD central office staff charged with the responsibility for correcting errors and/or requesting additional information necessary to resolve the error. On a daily basis Suspended Claims Reports are generated for provider claims that do not match the authorizations for service. Claims that pass this validation are approved for payment.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the State's current electronic accounting system, the Nebraska Information System (NIS).

DDD also conducts internal QI activities related to the use of DDD funding. Claim and authorization data is queried to track trends in costs and service use by area, provider and statewide.

Financial Services tracks the use of Medicaid funding and provides monthly updates on the use of waiver funding relative to the budgeted amounts. This aids DDD in determining the efficacy of our efforts to enhance our monitoring and oversight of the use of waiver funding.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Individuals who have chosen to participate and receive waiver services are notified in writing by DHHS staff of the authorized funding amount at the time of choosing a provider and in the development of the service plan. Checks and balances are in place to assure accurate budget authorizations. The team determines the provider, amount, and type of services needed. The individual's SC creates the electronic budget authorization in Therap and their supervisor reviews and approves it. When the DSS completes the annual waiver redetermination and when the SC's Supervisor completes the service plan review, the budget authorization on Therap is matched with the information in the service plan. When discrepancies are found, the SC and SC supervisor take action to correct errors in the on-line authorization by revising the provider, service type, service amount, and/or dates of services. A pre-audit of all individual specialized provider claims is completed to assure the accuracy of coding and claim. Therap, Nebraska's current electronic system for budget authorization and claims processing, was designed to meet the CMS requirements and the HCBS DD waiver specifications. The system also completes a pre-audit of all claims as a part of the efforts to ensure accurate claims.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: as determined by the state DDD QIC or DDD Deputy Director

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Information about payment rates is made available verbally and in writing to waiver participants and providers by DHHS staff. The waivers and rate study are posted on the DHHS public website at http://dhhs.ne.gov/developmental_disabilities/Pages/developmental_disabilities_index.aspx.

Using the normal budgeting and appropriation process, the Legislature and Governor determine the appropriation level for the DD Aid budget program. The Nebraska Legislature appropriates funding for services, specifying the percentage of increase each budget year, or specifying how a special appropriation is to be spent. The increase in appropriation or a special designation determines the rate increase. DHHS determines the rates, and communicates these rates to the Governor's budget staff and to the Nebraska Legislature's Appropriation Committee.

Public hearings are held to provide opportunities for public comment on the Legislative Appropriations Bill. Dates of the hearings are posted on the Nebraska Legislative website, major newspapers in the state, and at the Nebraska State Capital or other state and public buildings in which the hearings are held. This waiver is a fee for service waiver.

In 2009, the Legislature approved a special appropriation for an assessment of the rate structure for DD services. The rates are based on a study on the actual costs of services conducted by a national consulting firm in 2010 and 2011. A number of tasks were completed to develop rates for services provided under the HCBS waivers 0394, 0396, and 4154. The consulting firm examined DDD's historical payment methodology, met with providers and surveyed stakeholders to gather public feedback about the current system, collected current cost and wage data from providers, utilized Bureau of Labor Statistics wage data, and researched rate methodologies used by other states.

In general, the model uses assumptions about types of employees, staffing levels, wage rates, benefits and administrative overhead ratios, vacancy rates for both employees and participants, and productivity factors. Rates include an FTE productivity factor of 1.15 (320 hours out of 2080 hours annually), based on the hours for absences due to vacation, sick time, holidays, training, administrative meetings, and activities.

Rates include non-direct cost allocation factors for taxes and benefits for each FTE, determining that the benefits factor is equal to 27.81% of total direct wage expenses. The current non-direct cost allocation factors are: Administration – 35.04%; Non-program contracted services – 3.27%; and program support – 36.0%. The cost of transportation is a non-direct cost allocation that is included in the rates.

The methodology assumes a 1:9 ratio of supervisor to direct staff oversight. Hourly and daily rates assume a direct service staff and supervisor oversight.

Hourly rates are based on one clock hour of service.

Hourly and daily rates for day habilitation services assume a direct service staff and supervisor oversight. Hourly rates are based on 1 hour of service and the total number of hours assumed for daily rate is 4 or more. A 110 percent adjustment factor was applied to Integrated Community Employment and a 105 % adjustment factor was applied to Vocational Planning because these are services that DDD promotes. Based on data reviewed and technical assistance provided to DD service coordination, a new service, Supported Integrated Employment, was developed to further promote employment opportunities for individuals. The hourly rate was developed by reducing ICE by fifteen percent and Vocational Planning service by ten percent.

Payments are not made for room and board, the cost of facility maintenance, upkeep, and improvement.

The methodology incorporates fixed hourly and daily rates for Day Habilitation, Workstation habilitation, Respite, and Retirement.

The methodology incorporates only fixed hourly rates for Integrated Community Employment, and Vocational Planning habilitation. The hourly rate includes a direct staff person and supervisor component in the base direct care cost, which takes into consideration benefits factors, non-direct cost allocation, FTE productivity factors, supervision span of control, residential rates or day rates, staffing ratios, and adjustment factors.

Day Habilitation and Workstation habilitation are continuous day services. When 4 or more hours of continuous day services are delivered in a typical workday within a usual forty-hour workweek, Monday - Friday, the provider of continuous day services may bill a daily rate. When less than 4 hours of continuous day services are delivered, reimbursement is at an hourly rate.

When both continuous and intermittent services are delivered during day service hours, which are typically during a 40-hour workweek, reimbursement is at an hourly rate.

The Behavioral Risk and Medical Risk service rates are both a fixed daily rate and were developed by the consulting firm based on input from provider agencies that were providing this service as a pilot service. The Behavioral Risk service rate includes reimbursement for supervising practitioner consultation, direct support staff and supervisor salaries and benefits, transportation services to and from community settings for persons for the purpose of receiving day habilitation (teaching and supporting) services, and management and overhead costs. The rate also incorporates "difficulty of support" factors, which are intensive behavioral supports, and ongoing safety supervision and supports.

The Medical Risk service rate includes reimbursement for services provided by a Registered Nurse, direct support staff and supervisor salaries and benefits, transportation services to and from community settings for persons for the purpose of receiving day habilitation services, and management and overhead costs. The rate also incorporates "difficulty of care" factors, such as but not limited to development of nursing plans, provision of complex medical treatments, training unlicensed direct support professionals, and oversight of delegation of health maintenance activities to the extent permitted under applicable state laws.
The Behavioral Risk and Medical risk services are reimbursed on a daily rate basis of 13.33 hours, and the staffing ratios are flexible and commensurate to meeting the needs of the individual.

The Team Behavioral Consultation (TBC) service rate is a cost adjustment model and includes staff salaries, benefits, and preparation time to review information and schedule the site visit; travel time which varies from 2 to 9 hours one

way; on-site time, which includes a preliminary meeting, observing the individual during all awake hours in all settings; and follow-up time, which includes providing report of consultation, conference calls or meetings as necessary, and post recommendation surveys. The rate of this service is adjusted annually, based on the previous year's cost of delivering team behavioral consultation.

Because retirement direct support staff do not provide habilitation services, the base wage rate is lower than the base wage rate for other direct care support staff who provide habilitation. The fixed rates developed by the consulting firm are based on usual and customary rates for similar Nebraska services. The rate includes direct support staff salaries and benefits, management costs, and staffing levels. The retirement service is reimbursed on a daily rate basis of 7.39 hours. When retirement service is delivered intermittently, the rate is hourly, with a basis of 3.69 hours of delivered service.

The hourly rates for Respite services and Community Living and Day Supports (CLDS) delivered by independent providers are based on usual and customary rates for independent providers funded through other DHHS programs. DHHS is responsible for issuing a guideline for the range of rates for Respite services and CLDS. The authorized annual funding amount for any combination of Assistive Technology and Supports, Vehicle Modifications, and Home Modifications is limited to $5,000. The rates for Assistive Technology and Supports, Home Modification, Personal Emergency Response System, and Vehicle Modifications are based on usual and customary rates for independent providers funded through other DHHS programs. DHHS is responsible for setting the rates.

Information about payment rates is made available verbally and in writing to waiver participants and providers by state DHHS staff. The waivers and rate study are posted on the DHHS public website.

The determination of funding for individuals is determined using the Objective Assessment Process as stated in statute and regulations. Funding is assigned based on an objective assessment of each person's abilities, to provide for equitable distribution of funding based on each person's assessed needs. This process has been used since 1999 for persons new to services or requesting an increase in their funding, and for all persons in services since July 1, 2014. Funding for Respite, Medical Risk service, and Behavioral Risk service, Assistive Technology and Supports, Home Modification, Personal Emergency Response System, and Vehicle Modifications is not determined using an objective assessment process (OAP).

The assessment to ascertain each person's skills, abilities, and needs is the Inventory for Client and Agency Planning (ICAP). State staff completes the ICAP assessment with input from the individual's teachers, para-educators, family members, and provider staff, as appropriate, as well as a review of substantiating documentation. This assessment is submitted to the DDD Central Office where the overall score is determined. An ICAP is completed for persons new to services, when a person adds either day or residential services or when they have a significant change in supports or abilities.

Additional funding may be requested when a waiver participant's needs cannot be safely met with funding solely based on the ICAP score. Based on input from the provider and guardian, if applicable, the team may submit a clinical rationale and supporting documentation to request an exception to the OAP. The amount of exception funding is determined administratively based on justification by the team of a temporary increased service need of the individual. To the base funding, determined by OAP, is added the cost of provider supports to mitigate any risks identified in clinical assessments.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow directly from providers to NFOCUS, the State's electronic local web-based claims payment system, which is a component of MMIS. Service Authorizations are sent to provider in Therap (Web-based Software as a Service system used for budgeting and case management). Service data is recorded in Therap by providers. Claims are then generated and sent to Service Coordinators for approval (in Therap) and then submitted for claims processing following the delivery of services

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services are authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the state's accounting system, the Nebraska Information System (NIS).

All payments are processed through its N-FOCUS sub-system, a recognized component of MMIS, and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.

The program under which a claim is paid is stored on each individual claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to the Nebraska Information System (NIS). N-FOCUS stores the timestamp and user ID for all new or updated information related to this process.

Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the Nebraska Information System (NIS). Claims are processed on a daily basis.

Direct billing of waiver services is provided to the State. Claims made to Medicaid are documented on the CMS-64 on a quarterly basis.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

a) When the individual was eligible for Medicaid waiver payment on the date of service.
Waiver services must be prior authorized before payment is made. Authorizations are based upon a determination that

the individual meets waiver eligibility criteria, that the services are identified in the approved service plan, and that the services are not available for funding through programs funded under section 602 (16) or (17) of the Individuals with Disabilities Education Act (P.L. 94 - 142) or section 110 of the Rehabilitation Act of 1973.

b) When the service was included in the participant's approved service plan.
The authorization and payment process includes the following steps:
1. Waiver eligibility of the individual is determined.
2. Waiver services are identified in the service plan.
3. Waiver service authorization, known as the budget authorization, is completed, indicating approved waiver services, waiver provider(s), dates of service, and authorized units of service.
4. Authorization is entered into Therap (Web-based Software as a Service system used for budgeting and case management) and then sent to NFOCUS, the state's electronic local web-based authorization and payment system.
5. Claims are generated in Therap based on service data entered by providers.
6. Upon verification by DHHS staff, claims are submitted to NFOCUS for processing. Edits in the Therap system verify client and provider eligibility, dates of service, units of service, and rates.

c) The services were provided.
All providers must sign an annual contract or agreement stipulating that the provider shall maintain records and documentation in sufficient detail to allow state staff to verify units of service provided to individuals as certified on the state billing document. Each billing document must be signed by the provider, certifying that the foregoing claim is accurate and all services provided were in compliance with applicable state regulations.

Each billing document must be electronically signed in Therap by the provider. This includes the documentation of services provision, the approval of that documentation, and the generation of the claim.

When non-specialized services are delivered by an independent provider, a record of services must be submitted that includes sufficient detail to allow state staff to verify the units of services provided and that is signed by the waiver participant or, if applicable, the family member/guardian. The record of services is forwarded to local DHHS staff who are responsible to review and verify the units of services billed by the providers.

The billing validation process verifies that the individual was eligible for Medicaid waiver payment on the date of service.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ◉ **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made through an electronic data system called N-FOCUS, which is a component of Nebraska's approved MMIS. N-FOCUS (Nebraska Family Online Client User System) determines eligibility and issues payments/benefits for 36 programs administered by Nebraska Department of Health and Human Services. All of the following functions are incorporated into the N-FOCUS application with the exception of the actual issuance of payment that is via the NIS application and is explained below.

(a) The process by which payments are made and the entity that processes payments.
After a client is determined to be eligible for Medicaid on N-FOCUS, a separate eligibility process is completed for eligibility for HCBS waiver services. Once waiver eligibility is established, a budget authorization is completed in Therap by the individual's service coordinator, and approved by the service coordinator's supervisor. The eligible individual, the waiver program and the waiver services are then linked to a provider approved to provide the service for the program.

The service, or budget, authorization specifies the individual authorized to receive the service, the provider authorized to provide the service, the program under which the service is to be provided, the specific service to be provided, the dates for which the authorization is valid, the rate, the rate frequency, and the maximum number of units for which the provider is authorized to bill. The completed budget authorization forms the basis for future claims to be submitted.

A claim must include: The provider that provided the service, the person who received the service, the budget authorization identification number, the service type, the dates of service, the frequency and rate authorized for the service, the actual number of units provided for the stated time period and the total amount claimed. When a claim is created on Therap, the system validates all submitted information against the budget authorization on file. Claims that fail to pass validation are suspended from processing for review by a local DHHS staff or DDD central office staff charged with the responsibility for correcting errors and/or requesting additional information necessary to resolve the error. Claims that pass this validation are electronically submitted to N-FOCUS and processed for payment.

During the validation process, individual claims that are approved for payment are linked to the specific waiver program under which the services were authorized. During nightly payments processing, a table is accessed for each claim under a waiver program. This table contains the current federal matching rate and the established accounts from which individual debits for the state and federal shares are to be drawn for each waiver program. This information is summarized on a voucher that is then sent to the state's accounting system, the Nebraska Information System (NIS).

(b) How and through which system(s) the payments are processed.
All payments are processed as described in item 1 above by DHHS through its N-FOCUS sub-system, and are subsequently sent to the Nebraska Information System (NIS), the accounting system for the State of Nebraska.

(c) How an audit trail is maintained for all state and federal funds expended outside the MMIS.
As described in item 1 above, the program under which a claim is paid is stored on each individual claim. For each program, a separate account is maintained from which to debit the federal and state shares based on the date of payment. Those account tables are maintained over time. When the payment is made, all claims for the same program are then summarized on a voucher and submitted to the Nebraska Information System (NIS). N-FOCUS stores the timestamp and user ID for all new or updated information related to this process.

(d) The basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
Federal funds are drawn from the designated accounts at the time an approved claim is set to Paid status and sent to the Nebraska Information System (NIS). Claims are processed on a daily basis.

In Nebraska, some DD provider agencies are public providers established by County Commissioners under interlocal agreements. Both private and public providers deliver Integrated Community Employment, Supported Integrated Employment, Day Habilitation, Vocational Planning service, Workstation service, respite, and Retirement, and the payment to these public providers does not differ from the amount paid to private providers.

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

  Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (•) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Vocational Rehabilitation Services within the Department of Education is a state government agency. Vocational Rehabilitation Services is a provider of assistive technology and supports, home modifications, and/or vehicle modifications and receive the same rates as all providers for those services.

In Nebraska, some DD provider agencies are public providers established by County Commissioners under interlocal agreements. Both private and public providers deliver Integrated Community Employment, Supported Integrated Employment, Day Habilitation, Vocational Planning service, Workstation service, respite, and Retirement, and the payment to these public providers does not differ from the amount paid to private providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- ◉ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid**

ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (•) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The state establishes the rates and those rates do not include any costs for room and board. The providers bill according to the established rates.

In Nebraska, the individual's SSI payment is for his/her room and board. The rates reflect the exclusion of room and board. Room and board costs are not included in the rates for the following services:
Group home residential service;
Companion home residential service;
Retirement service;
Respite;
Extended family home residential service;
Medical risk service; and
Behavioral risk service.

Payments for residential services are made to certified provider agencies of developmental disabilities services using a rate that contains the following elements of cost:
Salaries and benefits of frontline or direct care staff;
Salaries and benefits of supervisors of frontline or direct care staff;
Transportation services to and from facilities for person to receive habilitation services; and,
Administrative expenses of the certified provider related to residential habilitation and respite.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10293.82	5591.00	15884.82	151321.00	5053.00	156374.00	140489.18
2	10542.51	5871.00	16413.51	158887.00	5305.00	164192.00	147778.49
3	10801.53	6164.00	16965.53	166831.00	5570.00	172401.00	155435.47
4	11095.47	6473.00	17568.47	175173.00	5849.00	181022.00	163453.53

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
5	11419.02	6796.00	18215.02	183931.00	6141.00	190072.00	171856.98

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	**1400**	1400
Year 2	**1470**	1470
Year 3	**1540**	1540
Year 4	**1610**	1610
Year 5	**1680**	1680

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay on the waiver is based on the most recently filed 372 (waiver year 2013).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The distribution of users between each service type is based on service usage patterns during State Fiscal Year 2015. The total number of slots increase at an average rate of 5% annually and are distributed across all service types in the same proportion as the previous year.

Estimates for number of units per user assume utilization will remain the same as State Fiscal Year 2015.

Cost per unit estimates are based on published rates for waiver year 2015 and State Fiscal Year 2015 actuals with a 2.25% increase for each year.

This waiver does not cover the cost of prescribed drugs and therefore Factor D’ does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based on actual acute care expenditures for individuals on the waiver in State Fiscal year 2015. The average cost for acute care for this period was $5,325. Price increases of 2.25% were included for each year.

This waiver does not cover the cost of prescribed drugs and therefore Factor D'' does not include any costs for prescription drugs. Prescription drugs are covered as a State Plan service.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The average cost of institutional care per ICF-MR recipient was based on actual expenditures in State Fiscal year 2015. The average cost for this Fiscal year was $114,115. Price increases of 2.25% were included for each year.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on actual acute care expenditures for individuals in an ICF-MR in State Fiscal year 2015. The average cost for acute care for this waiver year was $4,812. Price increases of 2.25% were included for each year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Day Habilitation	
Integrated Community Employment	
Respite	
Assistive Technology and Supports (ATS)	
Community Living and Day Supports (CLDS)	
Home Modifications	
Personal Emergency Response System (PERS)	
Retirement Services	
Supported Integrated Employment	
Team Behavioral Consultation	
Vehicle Modifications	
Vocational Planning	
Workstation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						9891827.82
				GRAND TOTAL:		14411350.32
				Total Estimated Unduplicated Participants:		1400
				Factor D (Divide total by number of participants):		10293.82
				Average Length of Stay on the Waiver:		354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Hour	Hour	539	73.00	24.18	**951410.46**	
Day Habilitation Day	Day	553	159.00	101.68	**8940417.36**	
Integrated Community Employment Total:						**79705.12**
Integrated Community Employment	Hour	22	88.00	41.17	**79705.12**	
Respite Total:						**260583.10**
Respite	Hour	134	115.00	16.91	**260583.10**	
Assistive Technology and Supports (ATS) Total:						**16997.40**
Assistive Technology and Supports (ATS)	Occurrence	20	1.00	849.87	**16997.40**	
Community Living and Day Supports (CLDS) Total:						**1490014.64**
Community Living and Day Supports (CLDS)	Hour	223	578.00	11.56	**1490014.64**	
Home Modifications Total:						**43637.72**
Home Modifications	Occurrence	7	1.00	6233.96	**43637.72**	
Personal Emergency Response System (PERS) Total:						**326.50**
Personal Emergency Response System (PERS)	Monthly	1	10.00	32.65	**326.50**	
Retirement Services Total:						**1908.60**
Retirement Services Hour	Hour	2	10.00	20.33	**406.60**	
Retirement Services Day	Day	2	10.00	75.10	**1502.00**	
Supported Integrated Employment Total:						**184783.18**
Supported Integrated Employment	Hour	37	142.00	35.17	**184783.18**	
Team Behavioral Consultation Total:						**239362.20**
Team Behavioral Consultation	Occurrence	11	220.00	98.91	**239362.20**	
Vehicle Modifications Total:						**10969.64**
Vehicle Modifications	Occurrence	4	1.00	2742.41	**10969.64**	
Vocational Planning Total:						**1662133.20**
Vocational Planning	Hour	217	195.00	39.28	**1662133.20**	
			GRAND TOTAL:			**14411350.32**
			Total Estimated Unduplicated Participants:			**1400**
			Factor D (Divide total by number of participants):			**10293.82**
			Average Length of Stay on the Waiver:			354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Workstation Total:						**529101.20**
Workstation	Hour	68	230.00	33.83	**529101.20**	
				GRAND TOTAL:		**14411350.32**
				Total Estimated Unduplicated Participants:		**1400**
				Factor D (Divide total by number of participants):		**10293.82**
				Average Length of Stay on the Waiver:		354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**10626025.59**
Day Habilitation Hour	Hour	566	73.00	24.72	**1021380.96**	
Day Habilitation Day	Day	581	159.00	103.97	**9604644.63**	
Integrated Community Employment Total:						**85210.40**
Integrated Community Employment	Hour	23	88.00	42.10	**85210.40**	
Respite Total:						**280357.35**
Respite	Hour	141	115.00	17.29	**280357.35**	
Assistive Technology and Supports (ATS) Total:						**18248.79**
Assistive Technology and Supports (ATS)	Occurrence	21	1.00	868.99	**18248.79**	
Community Living and Day Supports (CLDS) Total:						**1598678.64**
Community Living and Day Supports (CLDS)	Hour	234	578.00	11.82	**1598678.64**	
Home Modifications Total:						**50993.84**
Home Modifications	Occurrence	8	1.00	6374.23	**50993.84**	
Personal Emergency Response System (PERS) Total:						**333.80**
				GRAND TOTAL:		**15497496.53**
				Total Estimated Unduplicated Participants:		**1470**
				Factor D (Divide total by number of participants):		**10542.51**
				Average Length of Stay on the Waiver:		354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS)	Monthly	1	10.00	33.38	333.80	
Retirement Services Total:						1951.60
Retirement Services Hour	Hour	2	10.00	20.79	415.80	
Retirement Services Day	Day	2	10.00	76.79	1535.80	
Supported Integrated Employment Total:						199146.48
Supported Integrated Employment	Hour	39	142.00	35.96	199146.48	
Team Behavioral Consultation Total:						267009.60
Team Behavioral Consultation	Occurrence	12	220.00	101.14	267009.60	
Vehicle Modifications Total:						11216.44
Vehicle Modifications	Occurrence	4	1.00	2804.11	11216.44	
Vocational Planning Total:						1785513.60
Vocational Planning	Hour	228	195.00	40.16	1785513.60	
Workstation Total:						572810.40
Workstation	Hour	72	230.00	34.59	572810.40	
				GRAND TOTAL:		15497496.53
				Total Estimated Unduplicated Participants:		1470
				Factor D (Divide total by number of participants):		10542.51
				Average Length of Stay on the Waiver:		354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						11407198.26
Day Habilitation Hour	Hour	594	73.00	25.28	1096191.36	
Day Habilitation Day					10311006.90	
				GRAND TOTAL:		16634355.53
				Total Estimated Unduplicated Participants:		1540
				Factor D (Divide total by number of participants):		10801.53
				Average Length of Stay on the Waiver:		354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	610	159.00	106.31		
Integrated Community Employment Total:						**90900.48**
Integrated Community Employment	Hour	24	88.00	43.04	**90900.48**	
Respite Total:						**300913.60**
Respite	Hour	148	115.00	17.68	**300913.60**	
Assistive Technology and Supports (ATS) Total:						**20436.65**
Assistive Technology and Supports (ATS)	Occurrence	23	1.00	888.55	**20436.65**	
Community Living and Day Supports (CLDS) Total:						**1712064.90**
Community Living and Day Supports (CLDS)	Hour	245	578.00	12.09	**1712064.90**	
Home Modifications Total:						**52141.20**
Home Modifications	Occurrence	8	1.00	6517.65	**52141.20**	
Personal Emergency Response System (PERS) Total:						**341.40**
Personal Emergency Response System (PERS)	Monthly	1	10.00	34.14	**341.40**	
Retirement Services Total:						**1995.60**
Retirement Services Hour	Hour	2	10.00	21.26	**425.20**	
Retirement Services Day	Day	2	10.00	78.52	**1570.40**	
Supported Integrated Employment Total:						**214074.94**
Supported Integrated Employment	Hour	41	142.00	36.77	**214074.94**	
Team Behavioral Consultation Total:						**295752.60**
Team Behavioral Consultation	Occurrence	13	220.00	103.41	**295752.60**	
Vehicle Modifications Total:						**14336.05**
Vehicle Modifications	Occurrence	5	1.00	2867.21	**14336.05**	
Vocational Planning Total:						**1914067.35**
Vocational Planning	Hour	239	195.00	41.07	**1914067.35**	
Workstation Total:						**610132.50**
Workstation	Hour		230.00	35.37	**610132.50**	

GRAND TOTAL:	**16634355.53**
Total Estimated Unduplicated Participants:	**1540**
Factor D (Divide total by number of participants):	**10801.53**
Average Length of Stay on the Waiver:	354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		75				
				GRAND TOTAL:		16634355.53
				Total Estimated Unduplicated Participants:		1540
				Factor D (Divide total by number of participants):		10801.53
				Average Length of Stay on the Waiver:		354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**12256114.50**
Day Habilitation Hour	Hour	624	73.00	25.85	**1177519.20**	
Day Habilitation Day	Day	641	159.00	108.70	**11078595.30**	
Integrated Community Employment Total:						**96822.00**
Integrated Community Employment	Hour	25	88.00	44.01	**96822.00**	
Respite Total:						**324355.20**
Respite	Hour	156	115.00	18.08	**324355.20**	
Assistive Technology and Supports (ATS) Total:						**21804.96**
Assistive Technology and Supports (ATS)	Occurrence	24	1.00	908.54	**21804.96**	
Community Living and Day Supports (CLDS) Total:						**1843172.64**
Community Living and Day Supports (CLDS)	Hour	258	578.00	12.36	**1843172.64**	
Home Modifications Total:						**59978.61**
Home Modifications	Occurrence	9	1.00	6664.29	**59978.61**	
Personal Emergency Response System (PERS) Total:						**349.00**
Personal Emergency Response System (PERS)	Monthly	1	10.00	34.90	**349.00**	
Retirement Services Total:						
				GRAND TOTAL:		17863707.16
				Total Estimated Unduplicated Participants:		1610
				Factor D (Divide total by number of participants):		11095.47
				Average Length of Stay on the Waiver:		354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
						2040.20
Retirement Services Hour	Hour	2	10.00	21.73	**434.60**	
Retirement Services Day	Day	2	10.00	80.28	**1605.60**	
Supported Integrated Employment Total:						**229585.60**
Supported Integrated Employment	Hour	43	142.00	37.60	**229585.60**	
Team Behavioral Consultation Total:						**302416.40**
Team Behavioral Consultation	Occurrence	13	220.00	105.74	**302416.40**	
Vehicle Modifications Total:						**14658.60**
Vehicle Modifications	Occurrence	5	1.00	2931.72	**14658.60**	
Vocational Planning Total:						**2055200.55**
Vocational Planning	Hour	251	195.00	41.99	**2055200.55**	
Workstation Total:						**657208.90**
Workstation	Hour	79	230.00	36.17	**657208.90**	
				GRAND TOTAL:		**17863707.16**
				Total Estimated Unduplicated Participants:		**1610**
				Factor D (Divide total by number of participants):		**11095.47**
				Average Length of Stay on the Waiver:		354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation Total:						**13156508.43**
Day Habilitation Hour	Hour	655	73.00	26.43	**1263750.45**	
Day Habilitation Day	Day	673	159.00	111.14	**11892757.98**	
				GRAND TOTAL:		**19183948.21**
				Total Estimated Unduplicated Participants:		**1680**
				Factor D (Divide total by number of participants):		**11419.02**
				Average Length of Stay on the Waiver:		354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integrated Community Employment Total:						**102960.00**
Integrated Community Employment	Hour	26	88.00	45.00	**102960.00**	
Respite Total:						**346407.60**
Respite	Hour	163	115.00	18.48	**346407.60**	
Assistive Technology and Supports (ATS) Total:						**23224.50**
Assistive Technology and Supports (ATS)	Occurrence	25	1.00	928.98	**23224.50**	
Community Living and Day Supports (CLDS) Total:						**1979904.32**
Community Living and Day Supports (CLDS)	Hour	271	578.00	12.64	**1979904.32**	
Home Modifications Total:						**61328.16**
Home Modifications	Occurrence	9	1.00	6814.24	**61328.16**	
Personal Emergency Response System (PERS) Total:						**356.90**
Personal Emergency Response System (PERS)	Monthly	1	10.00	35.69	**356.90**	
Retirement Services Total:						**3129.30**
Retirement Services Hour	Hour	3	10.00	22.22	**666.60**	
Retirement Services Day	Day	3	10.00	82.09	**2462.70**	
Supported Integrated Employment Total:						**245631.60**
Supported Integrated Employment	Hour	45	142.00	38.44	**245631.60**	
Team Behavioral Consultation Total:						**333009.60**
Team Behavioral Consultation	Occurrence	14	220.00	108.12	**333009.60**	
Vehicle Modifications Total:						**14988.40**
Vehicle Modifications	Occurrence	5	1.00	2997.68	**14988.40**	
Vocational Planning Total:						**2210551.20**
Vocational Planning	Hour	264	195.00	42.94	**2210551.20**	
Workstation Total:						**705948.20**
Workstation	Hour	83	230.00	36.98	**705948.20**	
				GRAND TOTAL:		**19183948.21**
				Total Estimated Unduplicated Participants:		**1680**
				Factor D (Divide total by number of participants):		**11419.02**
				Average Length of Stay on the Waiver:		354